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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

PART 3—(Pages 1-682)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

WEDNESDAY, MARCH 3, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:30 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. James Abdnor presiding.

Present: Senator Abdnor.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

STATEMENT OF DR. WILLIAM E. MAYER, ADMINISTRATOR

ACCOMPANIED BY:

- **DR. HERBERT PARDES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH**
- **DR. WILLIAM POLLIN, DIRECTOR, NATIONAL INSTITUTE ON DRUG ABUSE**
- **LORAN D. ARCHER, ACTING DIRECTOR, NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM**
- **ANTHONY L. ITTEILAG, DEPUTY ASSISTANT SECRETARY, BUDGET**
- **DR. WILLIAM F. DOBBS, SUPERINTENDENT, SAINT ELIZABETHS HOSPITAL**
- **JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH**

SUBCOMMITTEE PROCEDURE

Senator ABDNOR. The subcommittee will come to order. This morning we resume our fiscal year 1983 budget hearing on the Department of Health and Human Services.

We will hear from Dr. William E. Mayer, administrator of the Alcohol, Drug Abuse, and Mental Health Administration regarding programs in the fiscal year 1983 budget, including funding for St. Elizabeths Hospital.

PREPARED STATEMENT

Your full statement will be placed in the record, and you may proceed in any way you care. Maybe you ought to introduce the gentlemen accompanying you.

Dr. MAYER. Thank you very much.

[The statement follows:]

STATEMENT OF DR. WILLIAM E. MAYER

It is a pleasure to appear before this Subcommittee to discuss the President's budget request for alcoholism, drug abuse, and mental health activities in FY 1983. The Directors of the three Institutes comprising our agency are with me.

The Chairman and members of the Subcommittee are, of course, aware of the range and seriousness of the problems the Alcohol, Drug Abuse, and Mental Health Administration must address through its research, training, and prevention, and national leadership activities. We have just completed a new study which shows that in 1977 these problems cost our Nation a total of $106 billion. This staggering sum includes $49.4 billion attributed to abuse of alcohol, $40.3 billion to mental illness, and $16.4 billion to drug abuse. Although this is the most thorough cost estimate ever completed, we believe it still understates the true cost of these problems, due to the difficulty of factoring in such hidden costs as loss of productivity in the workforce caused by alcohol, drug abuse, and mental illness.

In my opinion, Mr. Chairman, the problems resulting from the abuse of alcohol rank among the most serious of our national public health issues. Approximately 10 million American adults are problem drinkers and each of them directly affects the lives of their families, coworkers, and others. But, of course, mental illness and drug abuse also add greatly to human suffering and social disruption. For instance, we know that between 8 and 14 million Americans each year suffer from varying degrees of clinical depression, and that an episode of schizophrenia will strike approximately 4 million of the people alive today in the United States sometime during their lives. Serious drug abuse problems also continue to plague our population. World statistics suggest that our young people have higher levels of illicit drug use than in any other Nation.

I am pleased to be able to report that significant progress is being made in our research effort to improve the prevention and treatment of these costly health problems. I will cite briefly only a few among our many research achievements.

One exciting development in the NIMH Intramural Research laboratories is the revolutionary new technique for visualizing functional events in the brain as they occur, without the need for any invasive procedure. This technique, known as the deoxyglucose method, has earned its principal developer, Dr. Louis Sokoloff, the 1981 Mary and Albert Lasker Clinical Research Award. It permits the use of positron emission tomography, or "PET" scanning of the living brain. The new technology is already being used in research and treatment centers to evaluate patients for a range of disorders, including schizophrenia, and has great potential for use in studying senile dementia, manic/depressive illness, and learning disabilities in children.

Another achievement I am honored to mention today is the series of discoveries of Dr. Roger W. Sperry of the California Institute of Technology, who won the Nobel prize for elucidating the role of the two hemispheres of the brain. Dr. Sperry's work has been supported by NIMH for many years.

In 1981, for the third year in a row, daily use of marijuana by high school seniors declined--and by a greater amount than in any previous year. Students are more concerned than ever before about health consequences of using marijuana. Cigarette, PCP, and tranquilizer use also dropped, and use of alcohol, cocaine, heroin, and barbiturates did not increase. These findings indicate that our various national and local prevention efforts are working, and give us impetus to persist and to do more.

One example of hard-won research knowledge that promises to have direct clinical application is an analytical test for diagnosing alcoholism devised by NIAAA scientists. The new procedure -- that some day may be applied right in the doctor's office or in a hospital admission room -- involves a special analysis of results from common blood tests. It could be a great boon to early identification of the problem and to overcoming resistance to treatment.

Mr. Chairman, these typify the progress agency programs have been making over the years, with your support and keen appreciation of these public health problems. Medical science is moving us ever closer to improving the treatment and control of these illnesses. Personally, as Administrator of the agency, I have been struck by the exceedingly high quality of the research being conducted and sponsored by these three Institutes. I am convinced that it is second to none. I also believe strongly that the scientific interactions and relationships that occur among alcohol, drug abuse, and mental health research activities under our coordinated administration contributes greatly to our progress.

Mr. Chairman, I have only touched upon our solid and growing record. With this as background, I will now outline activities we plan in 1983 to capitalize upon and continue our momentum.

These plans are constructed on the basis of four paramount agency goals: first, to continue the funding of our extramural research grant programs to ensure continued attention by our nation's best university-based scientists; second, to strenthen our intramural research program; third, to communicate the results of our research as effectively as possible to the treatment community, to other scientists, and to the public at large; and fourth, to offer continuing national leadership in these three health fields, as a source for a valuable national data base and technical assistance to States and communities as they develop and administer State and local services. I will discuss each of these elements in turn.

The 1983 budget request continues the policy adopted last year of emphasizing and providing increased support for research on the core problems dealt with in each Institute, and eliminates support of research less directly relevant to alcohol, drug abuse, and mental health disorders. The budget includes sufficient resources to support 450 new and competing grants, 32 research centers, 56 research contracts, and 925 research trainees.

The specific request for mental health research in 1983 is $149,962,000, an increase of $9.5 million above 1982. These funds would allow us to continue and intensify our studies of the major mental illnesses such as depression and schizophrenia, mental disorders in the aging and children, anxiety disorders, stress, and other problems.

Research in depression, for example, will seek to apply to clinical treatment the hypothesis that there is not a single diagnosis of depression, but rather many sub-types of depressive disorders, each amenable to remedy with a specific therapy.

Another promising area of study is development of drugs to treat memory impairment. NIMH would also refine its epidemiologic investigations and expand basic studies of brain and behavior.

Also planned for 1983 is expanded research on prevention. NIMH expects to use a portion of the requested $4.1 million in this area to establish a number of research centers to design new approaches to primary prevention, and to apply them in trial situations.

Turning to drug abuse research, the President's budget requests $46,356,000 for 1983, an increase of $6.5 million. These funds would enable us to focus on biological, behavioral, psychological, and epidemiological factors in drug abuse, and on development of more effective methods for treatment and prevention.

NIDA's research has played a pivotal role in recent strides in understanding how the human brain functions. Key discoveries by NIDA grantees pinpointed the sites in the brain activated by opiates, and the existence of the endorphins. These discoveries have implications in many health fields; the endorphins appear to be involved in a variety of compulsive disorders such as obesity, drinking, and even gambling, and in respiration, blood pressure, pain, and many other areas.

NIDA's research program in 1983 also would continue to explore the hazards and effects of marijuana use. As the recently released Ninth Report to Congress on Marijuana and Health indicate, much is known about marijuana abuse, but much more needs to be learned. In 1983, research would focus on the effects of marijuana smoke on lung function and brain structure. We also would begin a longitudinal study of chronic marijuana smokers to assess their long-term risks.

In addition, NIDA would pursue needed research on cocaine, whose use we view with increasing alarm. These studies would focus on various forms of self-administration of cocaine, such as smoking and injection, and on the nature of the cocaine psychosis.

Mr. Chairman, NIDA also is deeply committed to prevention and would expand its research effort to develop approaches for reducing and delaying the onset of drug abuse. Priority would be placed on peer-oriented prevention strategies that have proven successful for cigarette smoking, and on the family role in prevention.

The President's budget request for alcoholism research in 1983 is $32,911,000, an increase of more than $12 million over 1982 to expand knowledge of this major public health problem. The NIAAA research program would continue to aim at elucidating the many complex factors involved in producing the disease of alcoholism and conversely, the factors which act to protect some individuals from developing alcohol problems. Further genetic studies are needed, for example, since it is known that susceptibility to alcoholism can be inherited. Increased funds would support further development and refinement of techniques for diagnosis which can be inexpensively and readily used by physicians and other health care personnel. It is known that treatment begun early in the course of the disease has a much greater chance of success. Yet alcoholism is frequently not recognized, even by physicians.

Research also will be expanded into the prevention of alcoholism and the many problems that result form alcohol abuse. Increased research in this area will focus on developing improved prevention approaches for special populations, including young people; women of child-bearing age; children of alcoholics, who are at high risk for alcohol problems; and drinking drivers who account for one-third of all traffic fatalities. The increase in funds for NIAAA is also needed for further research into the role of alcohol in such diseases as cirrhosis, hepatitis and heart disease.

In line with the agency's primary mission, the budget request for 1983 also would strengthen the intramural research programs of each Institute. For instance, the mental health program would acquire and provide staff for a "PET" scanner. NIDA's intramural program would initiate an epidemiological field station in Baltimore to provide a more precise view of what happens during an outbreak of a new drug problem, and how urban drug use patterns change. Funds requested for NIAAA intramural research would allow that Institue to complete staffing of its new clinical research program at NIH, set to open this year.

Mr. Chairman, under the President's budget request for 1983, our clinical training program would be totally phased out, but research training will continue to be funded at only a slightly reduced level. This policy of an orderly phase out of funding for clinical training was first proposed in FY 1982. It is premised on the fact that Federal support for the past 30 years has resulted in the substantial development of academic mental health training departments. This national training capacity has been shaped and built over the years to the point that the training community is expected to continue to function productively without special developmental assistance.

Administration of the alcohol, drug abuse, and mental health services block grant program begun this year would be transferred to the Office of the Assistant Secretary for Health. Our agency, however, sees national data collection and the dissemination of research findings as important elements of its continuing mission. It is essential to share information derived from our national efforts with States, localities, and the public at large.

We see ourselves as becoming a valuable repository of data concerning the incidence and prevalence of alcoholism, alcohol problems, drug abuse, and mental illness as well as data cocerning the national capacity for dealing with these problems. Our role would encompass organizing, analyzing, and sharing these data.

An equally important task is effectively translating and communicating new research information to the treatment community, scientists, and the general public. Sufficient program support is critical if we are to meet these goals.

Mr. Chairman, I will be pleased to answer any questions you may have.

INTRODUCTION OF ASSOCIATES

Dr. MAYER. Thank you, Mr. Chairman. I am very honored to represent ADAMHA, the portion of the Public Health Service, Department of Health and Human Services that is charged by statute with activity which prevents, controls, and treats those human disorders connected with alcohol, drug abuse, and mental illness.

I am proud to be accompanied today by the directors of the three Institutes which make up ADAMHA. On my immediate right, Dr. Herbert Pardes, Director of the National Institute of Mental Health; on my left, Dr. William Pollin, Director of the National Institute on Drug Abuse; on my far left, Mr. Loran D. Archer, the Acting Director of the National Institute on Alcohol Abuse and Alcoholism; on my far right is Mr. Tony Itteilag, the Deputy Assistant Secretary of Health and Human Services for Budget.

Senator ABDNOR. We welcome the gentlemen to the committee.

Dr. MAYER. Thank you. With your permission, Mr. Chairman, although I have a written opening statement which has been offered for the record, I would like to make a few brief comments to set the stage for our discussion.

Senator ABDNOR. All right.

1983 REQUEST

Dr. MAYER. Our 1983 budget proposal involves about $17 million less than the current operating level under the continuing resolution, a reduction of about 5 percent.

It reflects a major change in direction and emphasis within our agency and within these three Institutes which, began last year and will be carried to completion in fiscal 1982.

REDUCTION IN FORCE

This time has been one of some tribulation and a great deal of triumph for these three Institutes. And I would like to mention briefly what has happened.

We have, as you know, sustained a reduction in force in our employee strength of about 700 people. In spite of that fact, however, most of the employees affected by the RIF have found employment.

Only a very few actually lost their jobs completely. Nonetheless, it was a period of turmoil in which the staffs of the Institutes performed, at least in my view, as a newcomer to Washington, in a truly exemplary and highly professional manner.

During this last year, we have had new studies on the total cost of these three areas of human illness, which even on the most conservative basis show that together they are costing the country at least $106 billion a year.

MAGNITUDE OF ADM PROBLEM

And, of course, the money lost doesn't begin to compare with the cost in human suffering and in the impact on families, friends, associates, employees, and employers of the people so afflicted.

We know, for example, that there are still at least 10 million adult alcoholics and serious problem drinkers in our national community. Less than 10 percent of them at any time are getting help for their disorders.

Now, we know that drug abuse among our youngsters is estimated by competent researchers to be at the highest level of any industrialized nation on Earth. The recent report by the Institute of Medicine on marihuana use showed that 1 in 14 teenagers—high school seniors—is smoking marihuana every single day.

We know also 41 percent of our high school seniors, by their own descriptions, engage in binge drinking of five or more consecutively taken drinks within every 2 weeks.

We know somewhere between 8 and 14 million people in this country are clinically depressed, an illness which impairs their ability to function, and is actually in many instances, a life-threatening one, since it leads to suicide.

We know about 4 million people in America who have or will have a profound disorder—schizophrenia—during their lifetime. All of this adds up to an enormous social and economic burden for the country. These diseases share with one another many centuries of serious stigma, of disgrace and the implications of sin and misbehavior and weakness; and for that reason, among others, they have lagged behind many other fields of health in developing a research base, a training base, and a service delivery base. These have flourished only in the last 15 or 20 years, with the establishment of ADAMHA and these three separate units.

In 1973 and 1974 there was a tremendous leap forward in national recognition of the problem and a growing acceptance of the fact that these are truly grievous human disorders that are treatable, and we have begun to make tremendous progress.

MENTAL HEALTH ACCOMPLISHMENTS

A few examples of that progress are worthy of note. For the first time, for example, we have a technology developed within the intramural research program of the National Institute of Mental Health for visualizing the actual functioning of the brain of living human beings, using a technique called the PET scan which uses some faintly radioactive glucose.

I think you may have a picture here before you—yes—showing the actual prints of what we can see within a living human brain, the difference here being the brain of a normal person and the brain of a schizophrenic. And we can see very marked differences in the way the activity is taking place.

The development of this device has resulted in the researcher who developed it, Dr. Louis Sokoloff, being given the highest American award for medical science this past year—the Lasker Award.

Moving on to some other achievements of the institutes, our extramural research program has, for 3 years, supported a scientist of great note in California named Dr. Roger Sperry, who received the Nobel Prize in medicine this year, one of only three people, for his work on the two sides of the brain, and the localization of function in these two sides.

DRUG ABUSE ACCOMPLISHMENTS

We have in the National Institute on Drug Abuse both collected a great deal of information of an epidemiological variety and also distributed a great deal of information about the serious health effects of marihuana. We believe this has had an impact on the youngsters whose use of it is still too high.

But we have, for the third year in a row—and we believe it is probably due to the prevention efforts of NIDA—found a distinct drop in the number of youngsters who are using that drug. That's a real achievement.

ALCOHOLISM ACCOMPLISHMENTS

In alcoholism, we have the problem both of a disease which appears to be genetically determined—not directly inherited, but certainly a predisposition that appears to be inherited—a genetically determined disease which is clearly progressive, which shortens life from 10 to 20 years, and which leads to fatalities. It also is a major cause of cirrhosis of the liver, the seventh leading cause of death in America.

We have discovered that alcoholism is not a disease reflecting weak character or poor moral values or emotional disability of an individual, but it is truly a definable, predictable, and treatable disease, treatable in the sense that we can control it although we can't cure it.

With respect to alcoholism, one of the major problems has been the reluctance of my own profession in medicine and other helpers to face up to the existence of alcoholism, especially in confronting the individual with the reality of his problem.

As a result, we have found that the overuse of alcohol has played a part in other serious physical disorders, even in cancer and heart disease. In response, we now have developed, or are in the final processes of developing, a relatively simple system for identifying significant alcohol problems by the use of standard laboratory techniques, involving a computerized analysis of a group of about 25 lab tests.

ALCOHOLISM DETECTION

We will be able to identify, long before it's clinically evident, the existence of early but important alcoholism problems in patients who have come to us for other things—for eye problems or stomach problems or other general health disorders. And that represents a great step forward.

Senator ABDNOR. You can detect that before it really occurs?

Dr. MAYER. We believe we are going to be able to do that; yes, sir. We also know that in the use of brain waves—electroencephalograms—it's possible to find an abnormal response which shows up on the brain waves of youngsters whose parents are alcoholic when they are stimulated with certain sounds. It's called auditory evoked response. We simply hook up the electroencephalogram, give various tones to the individual to hear, and when we get a particular pair of abnormal responses, there's a very high correlation with the existence of alcoholism in that person's family.

Now, that's an example of a noninvasive technique. We haven't had to draw blood, we haven't had to do anything. While this technique hasn't been fully realized yet, this may allow us to focus in really intensive prevention efforts on those people most likely, because of their genetic makeup and parental traits, to develop this disease if they drink at all.

Senator ABDNOR. Has it been practiced, or is it still too soon?

Dr. MAYER. It's already been done experimentally, sir. We have not had broad clinical trials, partly because the technology is still under refinement, but it's those kinds of things—the PET scan, the collection and dissemination of the data about the extent and the prevalence of drug abuse, the growing ability to identify the existence of alcohol problems before they actually show up in behavior—that are indicative of advances in these fields which outstrip anything in the previous 150 or more years.

1983 GOALS

Our goals, therefore, in 1983, involve continuing these great progressions in our knowledge and, importantly, in the dissemination of that knowledge out to the field where people are doing the diagnosis and the treatment. While the agency and its institutions will no longer support direct treatment services, because the money to do that has been transferred to the block grants, and while we will no longer be engaged in as massive a clinical training endeavor, or in any clinical training endeavor, as we have in the past; the fact is that we will continue to emphasize both investigator initiated extramural research and we will continue to strengthen our intramural and directly operated research programs.

ALCOHOL CLINICAL RESEARCH PROGRAM

And that very importantly includes three things I'd like to mention. We have arranged with the National Institutes of Health to open an alcoholism clinical research unit in the clinical center on the NIH campus. This has already been initiated and the staff is in the process of being recruited.

We have advertised for the director and we have transferred money to NIH for the refitting of the clinical space that we are going to use for patients. This should be a tremendous forward boost in the study of alcoholism.

PET SCANNER

In the National Institute of Mental Health, a major growth in our intramural program will accrue as a result of funds in the 1983 budget to provide for a new modern PET scanner, one that is no longer obsolete like the kind of model-T PET scanner that this photograph came from. That's a magnificent machine, obviously a very complex one, but it's also very cumbersome. It takes more than an hour to test a patient, and, if the patient is emotionally disturbed, keeping him dead still inside a machine surrounding his head is next to impossible.

The machine is too slow. We have only had access to it slightly more frequently than once a month for the last 15 months. So we have asked for a PET scanner which is over 5 times as fast, has much higher resolution and the ability to focus down on exactly where in the brain the drug is acting, or where in the brain the kinds of psychotic activity of the patient are taking place.

We will be able to accomplish our research with much greater dispatch and hugely increase our knowledge of how the human brain relates to the disorders of thinking and feeling.

ADDICTION RESEARCH CENTER

In drug abuse we will further our intramural program by completing a move which was begun several years ago. Several years ago our drug abuse intramural research program was in Lexington, Ky., at a medium-custody Federal facility there—a hospital. When the Bureau of Prisons determined it was not proper to allow prisoners to volunteer as subjects for drug abuse or other medical research, it was necessary to move our clinical portion out of Lexington and to Baltimore City Hospital, where we had developed an excellent relationship with the hospital, the Johns Hopkins Medical School, and the University of Maryland Medical School in Baltimore. But the animal labs—the preclinical basic science part of that research on drug abuse and on drug liability for abuse—remain in Lexington pending the finishing of the space at Baltimore City Hospital. And that space, in order to be completed properly, will require additional funds. However, without bringing those two elements together—the preclinical and the clinical research, the basic science research and the patient research, without that, the program will stumble along and not produce nearly the amount of information that it is capable of.

BRAIN REACTIONS TO DRUGS

Already research by NIDA has shown us tremendous advances in our understanding of the way brain cells react, for example, to opium and to other addictive drugs. We have been able to identify the fact that there are spots on the actual nerve tissue that accept certain kinds of drugs. They have demonstrated that valium and librium, which are notoriously given as the most widely disseminated drugs on Earth—in fact, I believe Americans consume some 10,000 tons of those pills every year—for these we have been able to find, through research conducted in NIDA, that apparently the brain creates its own substances very much like but better than these commercial varieties. A great deal of further research is going to be necessary to identify those compounds and put them to use.

SERVICE PROGRAM FUNDING DECREASE

That's just a very brief and superficial word on the expansion of our intramural program. We have shifted our emphasis away from clinical training and away from the direct transfer of services for two separate reasons that I think are important to talk about. We moved away from the direct provision of services, because today is unlike the situation 15 or 20 years ago, when services were very bad, indeed, in many States. In many places, the mentally ill were locked in little better than primitive cells in the basements of county hospitals. And I have seen many of them myself.

We were on the verge of having such a terrible condition of overcrowding in our State hospitals that human beings were actually made worse by going there. But that situation has dramatically changed in the last 15 years. There has been a growth in the country of community mental health programs so that a vast array of facilities for the care and treatment and long-term management of chronically mentally ill people actually exists now throughout the United States. It is certainly by no means perfect every place, but is far in advance of what existed before.

So it's been concluded—and I think wisely—that the Federal Government had done its part in stimulating that growth and in setting the tone and the patterns. Now for the tailoring that is different in Connecticut than it is in Montana, that's different in Alabama than it is in California—that tailoring of programs should be done by States and by the communities within those States who can best assess what their own needs are and how best to meet those needs.

CLINICAL TRAINING PHASEOUT

So we are withdrawing from the direct supervision and funding of service delivery of programs. We are also withdrawing from the funding and supervision of clinical training programs, in spite of the fact that there are assertions that we need still more psychiatrists and psychologists and psychiatric social workers and psychiatric nurses. This is because in the last 18 years, since these Institutes have been engaged in training, we have seen a 90-percent increase in the number of psychiatrists in America. There are now 31,000 practicing psychiatrists out there. We have seen a change in clinical psychology from the day when it was in its infancy to a 228-percent increase for a total of 31,200 clinical psychologists engaged in treatment. We have seen the psychiatric social worker group, and they were pioneers in the field of community mental health, we have seen their numbers grow by 200 percent to 30,000 master's level psychiatric social workers. And finally, we have seen the number of qualified master's degree psychiatric nurses increase by 600 percent to a total of 7,000.

DATA COLLECTION ACTIVITIES

No one pretends that's a perfect number. No one can really know what the perfect number is. But given the enormous research advances that we are seeing, the prospect for further tremendous contributions to our knowledge about the nature of these diseases and how to prevent them and to control them, training is of a lesser priority. However, the Institutes all feel a very important responsibility, not just to conduct research, but to collect the information garnered by research, to translate into usable terms, and to disseminate it around the country. We also feel responsible to continue to collect data on the availability of mental health and drug and alcohol treatment resources and how people get to them and whether they use them, to collect data and to share information from State to State on what prevention programs they have assessed and found really effective. These are the kinds of things which set apart the three Institutes in ADAMHA from all the other institutes of health as a very special kind of a national leader in these fields which, for so many years, for so many generations, have languished under the inattention and standoffishness and skittishness and stigma that has surrounded these three disorders.

So we are on the brink of great things. The Institutes have performed well, and as I said in the very beginning, I am exceedingly proud to have the privilege to be able to represent them.

And we will be happy to attempt to answer any questions that you or your staff may ask.

Senator ABDNOR. Thank you for a very interesting presentation.

It appears that your program is going to be carried out, and we are happy to hear that.

BLOCK-GRANT MONITORING

The Mental Health Systems Act of 1980 attempted to direct the resources to persons who were underserved by the community mental health centers. These included the chronically mentally ill, severely disturbed children and adolescents, and elderly persons. This act was repealed by the Omnibus Reconciliation Act, although the new block-grant legislation gives particular emphasis to meeting the needs of these underserved groups.

Now how does the Department plan to monitor the block-grant program in order to determine whether these underserved groups are receiving enough attention?

Dr. MAYER. First of all, the monitoring of service programs up until now has been a built-in and automatic part of the granting of funds. The condition for receipt of funds was reporting back to us exactly what you did with them. Under the block grant there is no mandatory reporting of that sort; however, the States—and we have contacted over 40 of them since the block grants were instituted—the States feel a need to share information with us and to get information back from us and have been most agreeable to participate with us in what we believe will be a very effective voluntary system of reporting the results of their activities.

USE OF BLOCK-GRANT FUNDS

Senator ABDNOR. What can you do if they fail to address these groups? Do you have any means of mandating States to provide certain services?

Dr. MAYER. The Reconciliation Act which set up the block grants does not give the agency authority to directly demand that the States conduct certain types of activities or to penalize them in any way if they don't; however, there is the provision in the act, of course, that if any citizens in a State—in a given State—find that the intention of the law is not being followed within that State, they can make that known to the Secretary of Health and Human Services, who can then conduct an investigation, in which I'm sure he would utilize our resources. If they are not, in fact, applying the block grant as intended by the Congress, then the Secretary is required to withhold funds from them under the block until such time as necessary corrections are made.

Senator ABDNOR. So they do have the incentive to carry out the purpose of the funds?

Dr. MAYER. Yes, sir.

TRANSFER OF BLOCK-GRANT PROGRAM

Senator ABDNOR. Well, the budget for fiscal year 1983 proposed to transfer the administration of the alcohol, drug abuse, and mental services block grant to the Office of the Assistant Secretary for Health. Now why does it make sense to transfer these responsibilities to the Office of the Assistant Secretary of Health, when most of the technical expertise resides in the Alcohol, Drug Abuse, and Mental Health Administration? Can you give us an answer to that?

Dr. MAYER. I think so, Senator. As you say, in this first year of the block grant, administration has rested in the Alcohol, Drug Abuse, and Health Administration.

Senator ABDNOR. What was left?

ADAMHA RESPONSIBILITY FOR BLOCK-GRANT PROGRAM

Dr. MAYER. The responsibility has remained in ADAMHA as a direct response to the wish of the Congress for this first year. This is a year of transition from project grants into block grants, and it has been appropriate since our Institutes were involved in all those projects and are necessary in making an orderly transition by the end of this fiscal year. However, by next year the States will be well aware of what their responsibilities and what their options and flexibilities are under the block. The administration of the block will consist largely of receiving their rather simplified applications for funds and issuing the checks.

With respect to things that are not administrative, but the giving of technical assistance, advice, help where it's asked for, I'm certain that the Office of the Assistant Secretary will expect us to provide that assistance where necessary. It's taking us 120 positions this year to phase down the project activities and help States take over. By the end of the year we will no longer need that and only 20 positions are expected to be required for the mostly mechanical aspect of administering the grant, and those 20 positions have been transferred to the Office of the Assistant Secretary. We don't think that that cuts us off in any way from the operators out there or from the ability to give them help.

STATE ADMINISTRATIVE COSTS

Senator ABDNOR. Well, you're doing a very fine job.

Although the block-grant legislation now permits the States to spend up to 10 percent——

Dr. MAYER. For administration.

Senator ABDNOR. How many of the States spend the full amount? Most of them?

Dr. Mayer. As an old State official, Senator, I would guess most of them will.

Senator Abdnor. Is that a reasonable amount, in your mind or about right, 10 percent for administration of programs like this?

Dr. Mayer. I think so, because of the fact that the treatment enterprise out there consists of a large number of facilities which have their own internal administration, who have for years been involved in detailed planning and submitting plans to the State. I don't think that there's really such a huge additional burden that's being imposed on the activity that it should require more than 10 percent of the block grants, and I would hope after the first year that it would require somewhat less than 10 percent, and it could be done.

Senator Abdnor. Once the thing is in place.

Dr. Mayer. Right. There's going to be readjusting and planning this year, now that the States have much greater flexibility than in previous years. So this year I can see them all spending their 10 percent.

Senator Abdnor. We will be able to tell from the numbers whether it's practical to cut back. Some of them will be leading the way.

FEASIBILITY OF TRANSFER OF RESEARCH TO NIH

Last November, this committee encouraged the Department to conduct an indepth study of the feasibility of transferring all your research to NIH. What are the advantages of such a transfer?

Dr. Mayer. We have studied that issue very carefully, and I think as dispassionately as we possibly could, because if it were to accrue to the benefit of these three Institutes to be under the administrative supervision of the National Institutes of Health, then we would surely support that. I can find no way in which that could possibly benefit these three Institutes, and I can visualize that it could do some very significant damage. I will try to be brief, but this is a subject dear to my heart, and I think it's a very important one.

I mentioned earlier that alcoholism and drug abuse and mental illness have all been stigmatized for many generations, that they all are different from cancer and heart diseases and stroke and dental problems and arthritis and digestive disorders. They all differ in several significant regards, the first being the fact that there's a tremendous need for increased public awareness and public education about the nature of these diseases.

The second is that all of them are manifested by behavioral changes. They have an impact on society which other kinds of diseases don't. All three of these categories of patients have in the past traditionally become or have been public charges. They're not your standard businessman who develops an ulcer and gets sick. In many cases the people who have been involved in the problems of drug and alcohol abuse have not been productive people to begin with. Many of the mentally ill persons, who have required so much of our National Treasury and our State treasury in every State, have been essentially unproductive and disabled since early life.

Now this sets apart this enormous group of people from other kinds of patients, and right now what we have seen happening is a growth in the very glamorous kind of research, a highly esoteric, highly sophisticated kind of laboratory research on these illnesses. This research involves the introduction of minute microscopic pipets into the brains of rats, evaluation of minute amounts of chemicals also that are so small as to be almost unimaginable. It is certainly as glamorous as anything today, and there's a growing enthusiasm in the research community for entering these fields that there has never been before. This has not been fashionable research. It hasn't been the fashion to research alcohol, drug abuse, or mental health any more than it has been fashionable to treat those illnesses, which is why psychiatrists, as a group, are the lowest paid of all medical specialties—a fact most people don't realize.

But in any case, it hasn't been fashionable in the past for scientists and researchers to get into these fields. But now that we are beginning to learn things about the endorphins and enkephalins and serotonin levels and about auditory evoked responses in the brain in people who may be predisposed to alcohol, there is a burgeoning interest among researchers for entering this field. There is also considerable anxiety among the biomedical-type research community, lest much of our substance be spent on behavioral science research which is often considered by laboratory scientists to be very soft, very uncertain; and, surely there have been examples of research into social problems and psychosocial problems in the past that have not seemed to be altogether relevant to the task at hand of treating and controlling these diseases. I think that there is a belief among the biomedical researchers that if they were to be incorporated into the National Institutes of Health, that somehow they would be safe, that their funds would not be eroded by the kinds of behavioral and psychosocial research that has characterized parts of these fields, although they are often very necessary parts since all three of these sets of disorders involve behavioral abnormalities.

This anxiety has led some of our own researchers to say, "Well, gee, NIH gets more money than ADAMHA does. It's more respectable medically. And wouldn't we be better off over at NIH?" And my initial feeling was that that's possibly true. But not as I look back over the original justification for setting up ADAMHA and setting the three Institutes together but apart from all the others. What that did was make a declaration on the part of the U.S. Government that these are indeed grievous human problems, that these problems relate to each other and are quite different from others. It was recognized that they have important biomedical components, but they have important social and behavioral components, and that they need the kind of specialized attention and the multiplicity of activity which they can have as a collection of three closely related and closely interacting entities. This is not characteristic of many of the Institutes at NIH, many of whom have large constituencies out there already made. We don't have large constituencies in mental health, drugs, and alcohol. We have good ones as far as they go, but we don't have enormous fundraising capabilities like the American Cancer Society, the March of Dimes, those kinds of public activities.

So I think it would be destructive. I think we would be giving a message to the community at large that we no longer think that these are special areas needing special attention, but that they should just simply take their place along with any other medical problems. I think that would be a very discouraging process.

Senator ABDNOR. Thank you.

ELIMINATION OF CLINICAL TRAINING PROGRAMS

I'll jump over to clinical training. The budget for fiscal year 1983 eliminates all funds for clinical training in the areas of mental health, drug abuse, and alcohol abuse. At the same time the report of the Graduate Medical Education National Advisory Committee indicates that there will be a shortage of psychiatrists and other mental care professionals over the next decade.

You said earlier that there are more and more coming on board. I wonder how you feel about the statement of the Graduate Medical Education National Advisory Committee?

Dr. MAYER. That committee, of course, consisted of eminent scholars and people knowledgeable in this field, and I would certainly not set myself up as some kind of authority to tell you their ideas are all wrong. On the other hand, our problems in increasing the numbers of people who are engaged in these fields have been problems mainly of recruitment, problems of a loss of interest among medical students for selecting these fields to go into. I don't feel that continued Federal support for clinical training is the sole or even the principal answer to what very possibly is a growing need for people in these fields.

As a matter of actual fact, our best estimate is that the Federal contribution to clinical training in this area probably accounts for not more than 5 to 10 percent of all the support from all sources for such clinical training in this country. And in a time like now where we have to pick and choose, like every family does when its resources are limited and its demands and desires are great, our highest priority is going to go to research, and for the moment clinical training does not achieve a high enough priority.

MALDISTRIBUTION OF PERSONNEL

Senator ABDNOR. As in other medical fields, I know that sometimes it isn't total numbers; it's to get them spread out in areas where they're needed. I don't know what you can do to force that.

Dr. MAYER. Of course, we have tried in requiring payback training from some of the people who have received their training at Federal expense to address the problem of maldistribution, but there aren't enough trainees with that kind of an obligation that we can say, "OK, you have to go to Sioux City, and you have to go up to the Red Bank Indian Reservation."

Senator ABDNOR. You don't have enough of that.

Dr. MAYER. No; we really don't. There is a terrible maldistribution problem in certain parts of the country, and I really don't know the solution to it.

RESEARCH ON SENILITY

Senator ABDNOR. Jumping over to the subject of senility. To what extent does research on senility at your agency overlap with that being done at the National Institute on Aging?

Dr. MAYER. Almost not at all, but I would like, with your permission, sir, to invite Dr. Pardes, the Director of the National Institute of Mental Health, to answer that.

Senator ABDNOR. Dr. Pardes?

Dr. PARDES. Senator, we have an understanding with other Institutes as to the aspects of senility that we will cover as opposed to areas that they will cover. For example, the NIMH has a major focus on understanding the roles of genetics and neurotransmitters in relation to senility, while the NINCDS is working on the more physiological aspects.

BEHAVIORAL ASPECTS OF AGING

In the aging area, our focus is on behavior, as some of the major problems relating to psychiatric illnesses of elderly involve behavioral problems. For example, one of the major reasons that older people are put into nursing homes is because of major memory deficiencies. Now our Institute is working on a variety of research projects to try to find methods to improve people's memory and, hopefully, sustain them outside of institutions and nursing homes for longer periods of time. This area of study would not typically be addressed by NIH.

Senator ABDNOR. Do you have great hopes for that?

Dr. PARDES. We have a number of research projects in the works. There are a number of psychopharmocological agents and behavioral techniques being studied. We can only say we're working on them at this point, but it's a little early to say we have anything that can be broadly used.

Senator ABDNOR. All right.

Dr. MAYER. There are a number of us older people telling them to hurry up.

Senator ABDNOR. Yes; I'm one of them.

All right. It would be a wonderful thing, I'm sure.

POSSIBLE MISDIAGNOSES OF SENILITY

Dr. PARDES. If I could make one other comment, Senator Abdnor. Another important point regarding senility and dementia is that a number of people who are diagnosed as having so-called dementia, in fact, have treatable psychiatric illnesses, such as depression. Our estimates are that 20 to 25 percent of people who are identified as having dementia, in fact, have other treatable illnesses and, if they're properly appraised, and if these other disorders are identified, the so-called dementia can be effectively treated. Again, this represents a significant finding which would probably have escaped a purely biomedical research approach.

IMPROVEMENTS IN DRUG ABUSE TREATMENT

Senator ABDNOR. All right. Is there any measurable statistic indicating that our ability to treat and cure drug addicts has substantially improved over the last 5 years as a result of NIDA programs dealing with cure of drug abuse? Has there been any measurable indication of our ability to treat and cure drug addicts? Has that improved over the last 5 years?

Dr. MAYER. I'd like to ask Dr. Pollin, the Director of the National Institute on Drug Abuse, to answer that, sir.

Senator ABDNOR. All right.

Dr. POLLIN. Yes; there has been, Mr. Chairman, and that evidence comes from a variety of sources. First, in spite of occasional regional upswings in heroin use resulting from increased supplies of heroin reaching the country from new sources, our studies show that the overall level of narcotic addiction in the country has slowly, but steadily, declined over the last decade. Second, the number of relapses, that is, the number of addicts who complete treatment and then go back on drugs, has decreased. Narcotic addiction needs to be thought of as a chronic, relapsing disease similar. let's say to diabetes. Decreasing the number of relapses is important because it prevents the relapsed addict from further contributing to the spread of narcotic addiction through the purchase or sale of narcotics. There have also been significant improvements and advances made in the types of therapy available, including the development of new drugs for treatment of narcotic addiction. These include narcotic antagonists and long-acting replacement drugs. And most important, perhaps, is the prospect of substantial additional progress for the first time as a result of our discoveries that the brain manufactures its own narcotic-like drugs.

RESEARCH ON THE ADDICTION PROCESS

This research has resulted in the first testable hypothesis as to why some people are vulnerable and become addicted, whereas other people experiment with drugs and don't become addicted. There are studies now underway to see whether some people have deficiencies in terms of their own production of the body's morphine-like drugs or other similar psychoactive drugs, and whether it can be such deficiencies that make some people to be very vulnerable to drug addiction and others much less subject to risk.

Senator ABDNOR. The number of drug addicts, is it dropping or increasing?

Dr. POLLIN. The number of narcotic addicts has dropped over the past decade. The number of people who are involved in the use of other categories of drugs overall has leveled off or has also begun to decrease.

NIDA ROLE IN HALTING DRUG TRAFFIC

Senator ABDNOR. What, if anything, are you doing to assist in halting the flow of illegal drugs into the United States? Do you work on that end at all?

Dr. POLLIN. No, Mr. Chairman. The Federal strategy is based on the notion that there have to be reductions in both the supply and demand for illicit drugs. It's in the supply reduction area that the amount of substances coming into the country is dealt with, and that's primarily the responsibility of the Drug Enforcement Agency and a number of other programs which attempt to reduce supplies or interdict their introduction into the country. Our work is in the other half of the equation, which is known as the demand reduction. It is encouraging to note that during the past 3 years, though perceived availability of drugs such as marihuana has remained at a high level, there is strong evidence of a significant reduction in the demand for drugs, and that high school seniors, for example, show a substantial increase in their perception of the risk associated with the use of marihuana. There has also been a significant reduction in the actual percent of high school students who use marihuana with any regularity.

Senator ABDNOR. I'm glad to hear that. Last week I visited some of our Custom facilities. They do yeoman work. We could do a lot more for them. I hope maybe in some way we might come up with some additional help. I'm happy to hear that though drugs seem to be readily available, they're not using it quite as much.

BUDGET INCREASE FOR ALCOHOL RESEARCH

The President has proposed approximately a $12 million increase for alcohol research. Now when the administration is trying to balance the budget is this a necessary increase?

Dr. MAYER. I believe it is, and I'd like to ask the Acting Director of the National Institute on Alcohol Abuse and Alcoholism to address that.

Senator ABDNOR. All right.

Mr. ARCHER. Mr. Chairman, we feel that this is a significant amount which is needed because, in fact, at this point in time we are playing catchup. The problem of alcoholism and alcohol abuse is an enormous problem in the Nation. The $12 million, which we are pleased to see the President requesting is primarily to provide an additional $3 million to complete the clinical research program at the National Institutes of Health. This is a major effort we began in fiscal year 1982 which we wish to fully implement in fiscal year 1983. This will enable us to carry on some of the research we have been developing in many areas such as early diagnostic techniques in cooperation with the staff of the National Institutes of Health. We also see this as an opportunity to stimulate collaborative efforts with the National Heart Institute, the Cancer Institute, and other Institutes to further expand their interests—and appropriately so—in the area of alcoholism.

In addition, we wish to continue the expansion and development of the alcohol research center program which has begun research in the electrical stimulation, auditory stimulation techniques, which we believe will open up some important new frontiers of study of the area of alcohol abuse and alcoholism.

DEMONSTRATION PROJECT WITH HCFA

We have included in the research budget $1 million to continue the cooperative effort with the Health Care Financing Administration to test the feasibility and effectiveness of providing alcoholism treatment to medicare and medicaid recipients in less costly settings. We have learned in the past 10 years that alcoholism is treatable and that alcohol programs are quite effective. So we have been working closely with the Health Care Financing Administration, since a major portion of the hospital care costs across the country is alcohol-related, to assist them in demonstrating low-cost alternatives of care.

The seven States involved in that demonstration expect to realize up to $20 million in savings over a 4-year period. If this project is successful—we expect it will be—and if we can expand outpatient coverage to the 57 States and territories, then we project a savings to the Federal Government of $320 million over a 4-year period by reimbursing less costly outpatient care across the Nation for medicare beneficiaries and medicaid recipients.

The last point I would like to make is, as I said earlier, our claim of catchup here in alcohol research is—as Dr. Mayer mentioned earlier—that there has always been a stigma around both research in this area and treatment. We believe in the last 10 years we have overcome a great deal of that stigma. We have started to realize some opportunities which did not exist before. Therefore, over half of that $12 million will go into the expansion of research grants to individual researchers. But I would like to put that into perspective. The fact is that this $6 million increase will only be a 5-percent increase over what was being spent for extramural research grants by our Institute in 1974. While it appears that $12 million is a large increase, it has to be recognized that it's on a rather small base. We are really, in effect, trying to catch up to a level of research commensurate to the burden of illness.

Senator ABDNOR. Well, thank you, Mr. Archer. I know that we have some additional questions that we will give to you. If you will provide the answers in writing, we will be very appreciative.

I certainly do thank you gentlemen for your very fine presentation today. I appreciate it very much.

Thank you.

St. Elizabeths Hospital

STATEMENT OF DR. WILLIAM E. MAYER, ADMINISTRATOR, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

ACCOMPANIED BY:

DR. HERBERT PARDES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH
DR. WILLIAM F. DOBBS, SUPERINTENDENT, ST. ELIZABETHS HOSPITAL
JAMES E. PITTMAN, EXECUTIVE OFFICER, NATIONAL INSTITUTE OF MENTAL HEALTH
ANTHONY L. ITTEILAG, DEPUTY ASSISTANT SECRETARY, BUDGET

SUBCOMMITTEE PROCEDURE

Senator ABDNOR. Now we will hear from Dr. Mayer and others regarding St. Elizabeths Hospital.

I'll ask you, Dr. Mayer, to introduce the members of the panel.

INTRODUCTION OF ASSOCIATES

Dr. MAYER. Yes, Mr. Chairman. It's a pleasure to introduce to you Dr. William Dobbs, the superintendent of St. Elizabeths Hospital, on my left; and Mr. James Pittman, on my far left, the Executive Officer of the National Institute of Mental Health.

Dr. Pardes will remain, the Director of the National Institute; and Mr. Itteilag, from the Department of Health and Human Services.

Senator ABDNOR. All right. You may proceed.

INCREASED FINANCIAL RESPONSIBILITY FOR THE DISTRICT OF COLUMBIA

Dr. MAYER. I would like to introduce our proposal for the 1983 budget for St. Elizabeths Hospital, which includes a reduction in the Federal contributions based on the assumption of additional revenues from other sources, including from the District of Columbia.

A major reason for this shift of responsibility for the patients at St. Elizabeths arises from the fact that approximately 90 percent of all the patients in that hospital are District of Columbia residents; yet the District, by virtue of a cap on their contribution to the cost of operating that hospital, has for a number of years been limited in what it had to pay for those services.

In fact, in this past year, they only have supplied 19 percent of the cost of operating the hospital. In connection with that, we will shortly be submitting a proposal to establish a federally supported but independent corporation in whose direction the District will play a major part with the Federal Government. This organization will foster and stimulate and make possible billing and collection of third-party payments for patients which have not been achievable under the present fragmented system of organization.

Senator ABDNOR. Going back to the third party? The family, you mean?

Dr. MAYER. No, sir. Dr. Dobbs will explain that in a little more detail. But by third party, I mean insurance, Federal agencies like medicaid and medicare.

Senator ABDNOR. Oh.

Dr. MAYER. So without attempting to go into any more detail, sir, I welcome whatever questions you may have.

Senator ABDNOR. If the 1983 budget reduces the support by $24 million to St. Elizabeths, how do you expect the District of Columbia to make up that difference?

Dr. PARDES. Senator Abdnor, the supposed increase in burden for the District has to be looked at carefully. The actual increase for the District is $26.7 million, and $14.1 million of that amount represents the Federal match for medicaid reimbursable services. Another $5.5 million will be paid by the District only, if outplacement of candidates for nursing home care does not occur. The District previously agreed to this commitment pursuant to the *Dixon* v. *Schweiker* case, and this amount only represents one-third of the actual costs. The remaining $7.1 million represents approximately 10 percent of the portion of the District of Columbia inpatient costs now being subsidized from Federal funds. In summary, we are proposing a District of Columbia commitment which still represents less than the true cost of care, and which in part was either foreseen by the District or is available from medicaid.

The increase in District responsibility, then, would still only be a small part; and the plan would call for a gradual increase over about a 10-year period.

Senator ABDNOR. A gradual phasing in?

Dr. PARDES. That's right. Over a 10-year period.

Senator ABDNOR. The $24 million isn't a realistic figure then; is it?

Dr. PARDES. As I indicated earlier, a good portion of that money was either already understood to be committed to the Dixon plan, or some that would come from medicaid sources; again, a part of which would not be District responsibility.

But if you look at the proportion of patients, as Dr. Mayer mentioned earlier—the proportion of patients that come from the District and the proportion of payments made by the District, they are really quite disparate from each other. The District has over 90 percent of the patients on the rolls, but pays only 19 percent of the hospital's costs.

What this plan represents is a gradual process of making them more parallel—the number of patients served from the District would be paralleled by contributions the District would make over a period of 10 years.

CORPORATION PROPOSAL

Senator ABDNOR. OK. The budget assumes that legislation will be enacted to establish a Government-sponsored nonprofit corporation to administer St. Elizabeths Hospital.

Now, what has been the reaction of the District of Columbia officials to this proposal?

Dr. PARDES. The District officials have been parties to the conversations with regard to the development of the corporation, and I think one of the nice features of the corporation idea at this point is that the general principles have got broad support from all of the concerned parties.

There are details yet to be worked out, but conceptually there has been general support, as I understand, from the District.

Senator ABDNOR. Good. Let me ask you this: What happens to the budget request if the legislation proposed is rejected by the Congress?

Dr. PARDES. Could we have the Department spokesman please respond to that?

Mr. ITTEILAG. Senator, the budget proposal before you in terms of the dollars does not depend on the passage of that legislation. In other words, we are asking as part of the appropriations act that you include language in the bill that would allow the District to increase its reimbursements to the hospital and by that manner, we would be able to carry out the 1983 budget plan.

Now, that's not to say we don't want to move as expeditiously as possible in the direction of the corporation, and that legislation should be submitted to the Congress, I would say within the next couple of months.

So I think we have what I would characterize as a dual-track proposal for the consideration of the Congress at this time.

Senator ABDNOR. Thank you.

PREPARED STATEMENT AND SUBMITTED QUESTIONS

Well, gentlemen, I think that will conclude our questions and if we have any additional ones, we will submit them to you in writing. And we certainly thank you for your very fine presentation, Dr. Mayer.

Dr. MAYER. And we wish to thank you, Senator Abdnor. It's been a pleasure.

[The prepared statement along with the following questions which were not asked at the hearing but were submitted for response for the record follow:]

STATEMENT OF DR. WILLIAM E. MAYER

I appreciate the opportunity to appear before you to discuss the programs of Saint Elizabeths Hospital. The past year has been both eventful and successful for Saint Elizabeths with many long-standing issues either resolved or plans developed for their resolution. I would like to share with you our accomplishments.

Accomplishments

- We were recently informed that Saint Elizabeths Hospital has received a two year accreditation for clinical programs from the Joint Commission on Accreditation of Hospitals as a result of a survey made last October. The JCAH will return in the fall to ascertain whether progress continues in correcting life safety and therapeutic environmental deficiencies as a part of the Hospital's major five year renovation effort.

- Last October the Hospital was also surveyed and certified for continued participation in the Medicare program.

- Saint Elizabeths was one of the institutions which provided equipment and emergency medical teams to assist in the recent aircraft and subway disasters.

- We have reached agreement with counsel for the plaintiffs on an implementation plan in the Dixon v. Schweiker litigation. The plan incorporates District of Columbia and St. Elizabeths past accomplishments and future plans designed to shift the primary locus of treatment from a large inpatient facility to a comprehensive community based mental health services delivery system.

- The renovation of the physical plant continues to move ahead. Last year design work was started for five major projects, including renovation of two clusters of patient care buildings constructed between 1930 and 1940; improvements to the Hospital's rehabilitation medicine building; repair of five patient support facilities; and underground utilities systems. The design work on these projects is nearing completion and we expect that bids for actual construction will be requested on four of the five projects this fiscal year and the fifth project next fiscal year.

- Between 1965 and 1981 the Hospital's inpatient load has been reduced almost fourfold - from 6,148 in 1965 to 1,984 in 1981. This reduction has been accomplished despite the doubling of patient admissions. Such reductions reflect a dramatic decrease in the average length of inpatient hospitalization, accelerated outplacement, and an emphasis on community based intervention and treatment. The patient population was reduced this year by 74 even though inpatient admissions increased by four percent.

- We continue to strengthen our links with the District of Columbia, including the operation of an outstanding community mental health center and, more recently, the development and transfer to the District of the J.B. Johnson Nursing Care Facility.

FY 1983 Budget

The anticipated program budget of $128.4 million proposes to continue the FY 1982 operating level. The funding structure presented in this budget is one which shows a substantially reduced direct federal subsidy accomplished as a result of additional powers provided the Hospital to generate revenues. There would, for the first time, be authority to bill patients directly. The District of Columbia would be billed for services to its residents who are not otherwise able to pay. Similarly, Federal and other entities would be billed for the care of any of their beneficiaries referred to the Hospital. Medicare and Medicaid certification will be sought for all organizational components entering the corporation, and clinical support provided for NIMH intramural research carried out at the Hospital would be reimbursed by NIMH.

The additional revenue sources, most of which can be established through the proposed changes in appropriation language, will increase anticipated reimbursement income by $37.6 million over the amount received under the old funding structure. The general policy of the FY 1983 budget's funding structure proposes that the District will pay an increasing share of its residents' care. We expect that the District will increase its contribution over the next ten years so that in ten years it will be paying the full cost of its residents' care. The major share of the District's increased contributions, approximately $14.1 million, will be derived from the Federal Medicaid contribution. Another $12.6 million represents increased income from the District of Columbia. The $12.6 million amount includes approximately $7.1 million resulting from the District paying an increased share of the actual cost of care for its inpatients, plus approximately $5.5 million in reimbursements for D.C. resident patients receiving nursing care, and who are inappropriately located at the Hospital. If these nursing care patients are outplaced in the community no reimbursement would be paid to the Hospital and the scope of the Hospital's activities would be reduced accordingly. Payments from other Federal agencies for care of their legal beneficiaries will account for another $5.2 million in reimbursements. Presently the cost of caring for patients from other Federal agencies is included in the basic Hospital appropriation. The remaining $5.7 million in additional outside income will reflect the reimbursement for NIMH research support and a variety of other sources, including collections from private patients.

Establishment of Corporation

For many years one of the most complex issues relating to Saint Elizabeths Hospital has been to implement a workable, financially realistic plan which (1) accurately reflects the Hospital's primary role of mental health care delivery to the District of Columbia citizens and (2) allows the Hospital to better coordinate services with the components of the local health care delivery system. The 1983 budget and the legislation we shall propose as part of the FY 1983 legislative program offer a plan which will effectively integrate the Hospital with the mental health care system of the District of Columbia.

The legislation would establish a government-sponsored, non-profit private corporation to administer Saint Elizabeths Hospital and include certain public mental health and substance abuse services now operated by the District of Columbia government. If this proposal is enacted the budget now before you will be merged with those of the District of Columbia components becoming a part of the corporation. The mission of the corporation will be to provide mental health and substance abuse services to residents of the District of Columbia and to others as appropriate.

The corporation proposal provides a variety of benefits not now available:

- Mental health care for the District of Columbia will be unified under one administrative authority, thereby increasing economy and efficiency;
- The District's authority and responsibility for the mental health care system will be enhanced;
- We can facilitate the implementation of the Dixon v. Schweiker consent order and shift the primary locus of treatment from a large inpatient psychiatric institution to a community-based system.
- The governing authority of the new system will have greater management independence and flexibility, thereby making it singularly accountable for results; and finally
- There will be encouragement and incentives for all mental health system components to collect available reimbursements for services provided, thereby reducing direct governmental subsidies.

The budget before you assumes that the corporation legislative proposal would be enacted and implemented on or near July 1, 1983.

Mr. Chairman, I will be pleased to answer any questions which you or members of the Committee may have.

Questions Submitted by the Subcommittee

BLOCK GRANT EMPHASIS ON UNDERSERVED

Question: The Mental Health Systems Act of 1980 attempted to direct resources to persons who were underserved by the Community Mental Health Centers. These included the chronically mentally ill, severely disturbed children and adolescents, and elderly persons. This act was repealed by the Omnibus Reconciliation Act although the new Block Grant legislation gave particular emphasis to meeting the needs of these underserved groups. In your opinion should the Federal Government have an ongoing role to ensure that these special groups receive mental health services?

Answer: One of the major reasons for moving from categorical to block grants was to give the States flexibility to use

Federal funds to meet their particular needs. Decisions regarding the allocation of these funds to particular projects or to particular population groups must remain a State responsibility, not that of the Federal government. I feel confident that the States will use the block grant funds wisely and will give very high priority to meeting the needs of underserved groups.

Apart from the block grant, ADAMHA will continue other efforts which will examine and bring to people's attention the needs of the elderly, the chronically mentally ill, and disturbed children and adolescents. They remain important population groups for continued research and demonstration efforts, for example. We also expect to collect epidemiological data on the incidence of mental illness among these groups and relate this information, along with research findings, to the States for use in their decision-making process. These and related prevention work will comprise an important role in ADAMHA's continued national leadership in the mental health area.

Question: Does the Department have any plans for encouraging the States to give a greater priority to these groups?

Answer: The States will not be directly encouraged to devote their resources to any particular area, since we no longer feel that it is an appropriate Federal role. As mentioned above, ADAMHA will continue to examine and publicize the need for providing quality mental health services to underserved groups through a variety of mechanisms, including our research program, information dissemination, and direct technical assistance which requested by a particular State.

BLOCK GRANTS: TRANSFER TO OASH

Question: The budget for fiscal year 1983 proposes to transfer the administration of the Alcohol, Drug Abuse, and Mental Health Services Block Grant to the Office of the Assistant Secretary for Health (OASH). What position did the Secretary take with OMB regarding this proposed transfer?

Answer: The Secretary and the OMB are agreed that there are strong arguments for consolidating the administration of all block grants into a single agency. Two purposes will be served through consolidation of all block grant administrative functions. First, less Federal staff will be required to perform essentially the same oversight functions if administration of block grants is located in one office. Secondly, States will have a single contact within the Public Health Service regarding all questions on the block grants.

Question: How much money and how many positions are included in the OASH budget for administering the Alcohol, Drug Abuse, and Mental Health Services Block Grant?

Answer: The 1983 buget request for the Office of the Assistant Secretary for Health includes 20 positions and $1.0 million for administering the Alcohol, Drug Abuse, and Mental Health block grant.

Question: Is legislation required to accomplish this transfer?

Answer: No additional legislation is required to transfer administration of the block grant program from ADAMHA to the Office of the Assistant Secretary for Health. The Omnibus Reconciliation Act provided authority to the Secretary, DHHS to administer the block grant programs, and he has the authority to select which organizational unit within the Department administers them.

Question: How will the Office of the Assistant Secretary for Health respond to requests for technical assistance?

Answer: During 1982, ADAMHA has provided extensive assistance, advice and expertise to the States in the transition of alcohol, drug abuse, and mental health categorical programs to the block grant mechanism. That assistance has enabled the States to assume full responsibility for managing their grants so that in 1983, Federal management of the grants will be, for the most part, simply an administrative task. To the extent that detailed programmatic questions, including requests for technical assistance are received by the Office of the Assistant Secretary for Health, ADAMHA will continue to be available to provide necessary expertise.

Question: There are some who argue that the proposed transfer reflects OMB's view that the Federal government no longer needs to provide technical assistance to the States in the field of mental health or substance abuse services. Is this an accurate assessment of OMB's position?

Answer: Absolutely not. The OMB and the Department have agreed that the technical grants management and fiscal stewardship aspects of block grant administration will be shifted to the Office of the Assistant Secretary for Health (OASH) in the interest of greater efficiency. This proposed transfer, however, does not reflect this Administration's view that technical assistance to States is no longer necessary.

Instead, it is anticipated that ADAMHA will continue to provide States with any expert technical and program assistance on mental health or substance abuse services. As before, these offices will respond to questions, and gather and disseminate information that may prove useful to States in the daily administration of the ADM service programs.

FEDERAL ROLE UNDER BLOCK GRANTS

Question: Under the Block Grant legislation, the States will assume the responsibility for administering the Community Mental Health Centers as well as the drug abuse and alcohol abuse clinics funded through the previous program. Now that the management has been delegated to the States, what is the appropriate Federal role with respect to these programs?

Answer: Under the block grant legislation, the appropriate Federal role relates directly and primarily to States, and States have the primary responsibility for relationships with community level alcohol, drug abuse, and mental health programs. While we expect that local programs will enhance their relationships with the States, this will not preclude all communication with these programs by the Federal Government. Through our technical assistance, data collection, and information dissemination programs, we expect to remain in touch with many individual programs. We further expect to continue and improve communications with groups such as the National Association of Counties, the National League of Cities, and the United States Conference of Mayors as well as with the National Governors' Association, the National Conference of State Legislatures, the National Association of State Alcohol and Drug Abuse Directors, and the National Association of State Mental Health Program Directors.

Question: Will the Federal Government continue to encourage new and innovative approaches to service delivery?

Answer: The Federal Government will continue to encourage new and innovative approaches to services delivery through the conduct and support of research and demonstration projects. One such example is a Department activity currently being undertaken by the National Institute on Alcohol Abuse and Alcoholism, the Health Care Financing Administration, and the Office of the Secretary to explore the utilization in pilot sites of expanded Medicare and Medicaid benefits for non-hospital alcoholism services. Results of these and other demonstration programs will be widely distributed by means of our information network.

INFORMATION DISSEMINATION

Question: Will the Federal Government disseminate and publicize successful examples of providing mental health, drug abuse, or alcohol abuse services?

Answer: The Federal Government does intend to disseminate and publicize successful examples of providing mental health, drug abuse or alcohol abuse services and to serve as a convenor of meetings for sharing of information between States and other groups. Information will be disseminated to disparate audiences, including the public, research scientists, and to clinicians, so that public education and prevention efforts are enhanced, replication efforts can quickly be initiated, and the results of research can be quickly utilized in clinical application.

Question: How will the lastest research findings be made available to service organizations?

Answer: We will provide research findings to service organizations though a variety of mechanisms, including publication in in-house organs, newsletters, journals of professional organizations and associations, and the convening of conferences for sharing of information. We expect to rely heavily on national organizations of State program directors as well as to strengthen our relationships with national service organizations such as the National Council for Community Mental Health Centers, the Alcohol and Drug Problems Association of North America, and the National Council on Alcoholism.

BLOCK GRANT COORDINATION

Question: Will the Department continue to work directly with individual service providers, or will all of its communications be channeled through the State agencies?

Answer: While the Department will continue to work directly with individual service providers, we see the great bulk of our technical assistance activities to and through State Agencies. This is consistent with our belief that the Alcohol and Drug Abuse and Mental Health Services Block Grant sets up a new relationship between the Federal Government and the States, and a parallel relationship between the States and the local communities. We will, resources permitting, continue to be responsive to individual service providers, but since the State ultimately bears responsibility for local funding decisions we intend to make the State aware of requests from individual service providers and to work jointly with the State and the community group.

STATE ADMINISTRATIVE EXPENSES

Question: The Block Grant legislation permits the States to spend up to 10 percent of their allocation for administration. What is the total estimated amount spent for State administrative expenses in fiscal year 1982 and 1983?

Answer: We are not aware of total estimates State expenditures for administrative expenses in fiscal year 1982 other than that each State that has applied for a block grant has certified that it will not exceed the 10 percent maximum for administrative costs that is allowed by law. Before we approved any State's application for block grant funds we reviewed its application for satisfactory evidence that the various statutory requirements and assurances, including the maximum 10 percent assurance, were in fact made. The amount spent by States for administrative expenses will probably vary from State to State, but the law does not require the States to provide us with this detailed information.

Question: How does this amount compare to the amount of Federal administrative expenses prior to the Block Grant legislation?

Answer: Since we do not know exactly how much money the States will use for administrative purposes, it is not possible to compare them with prior Federal expenditures. However, should the States spend an amount near the maximum legal limitation of 10 percent, they would be spending well over 60 percent more than the Federal government had before the block grant legislation was implemented.

TRANSFER TO NIH

Question: Last November, this Committee encouraged the Department to conduct an in-depth study of the feasibility of transferring all your research to NIH. How much in administrative expenses could be saved with such a transfer?

Answer: Very little administrative expense would be saved by a transfer to NIH. NIH, in contrast to ADAMHA, has decentralized many administrative functions such as personnel management which are handled by each Institute. By contrast, in ADAMHA these functions are provided centrally by the Office of the Administrator. Transfer to NIH would require the decentralization and duplication of these centralized functions in each of the transferred ADAMHA Institutes. Moreover, many administrative and management systems are already shared with NIH, including intramural research procurement and NIH management fund activities, and program policy planning is often done on a joint basis (see below).

Question: What procedures are now followed to prevent any duplication with the research being done through NIH?

Answer: Numerous procedures are already in place to prevent duplication of research by ADAMHA and NIH. All research applications are received centrally and forwared to the appropriate ADAMHA or NIH Institute for review; and an applicant can have only one application pending for the same project. Program staff in the ADAMHA Institutes and in NIH Institutes such as those on Aging, Child Health and Human Development, and Neurology meet to dicuss appropriate boundaries and to share other information about applications received; reassignments of applications are sometimes made. Numerous coordinating committees and informal collaboration at the program level exist in areas of mutual interest such as nutrition and senile dementia. And in the intramural programs the Scientific Directors have a committee which meets regularly.

Question: To what extent would a consolidation increase productivity?

Answer: We do not expect that consolidation would increase productivity because the benefits of collaboration are already being realized. ADAMHA already works closely with the NIH in policy and program development and in meeting program goals, as noted above. The present policies assure that there is no greater duplication between an ADAMHA and an NIH Istitute than between sister NIH Institutes. Further, the missions of ADAMHA and NIH differ. ADAMHA is not solely a research organization; its experience with service programs and technical assistance capabilities make it a national resource for a wide range of activities to assist the States, in part through encouraging new and innovative approaches to services delivery. Transfer to NIH would inhibit these health services research, evaluation, and demonstration activities that give promise of increasing productivity.

RESEARCH GRANT INDIRECT COSTS

Question: How much money did the Alcohol, Drug Abuse, and Mental Health Administration spend on indirect costs in fiscal years 1980 and 1981 and how much is included in the budget for fiscal years 1982 and 1983?

Answer: The indirect costs paid on research grants for these four years are shown in the table below:

1980	1981	1982	1983
$43,098,000	$41,216,000	$35,867,000	$39,975,000

Question: How much money will be saved in 1983 as a result of this new policy?

Answer: The total savings for 1983 are $3,929,000.

Question: How do you assess the effect of this policy on the quality of research?

Answer: We anticipate that a change in the rate of indirect cost reimbursement will not affect the quality of research. The Department plans to conduct a study to closely assess the impact of this reduction in the near future. We can envision only one way in which this change might have an effect on the quality of research. This would be if institutions were to cut back on services to investigators. However, even this might just slow productivity rather than adversely affect quality. In general, we anticipate that institutions will look for other ways to meet indirect costs, e.g., by increasing efficiency of operations or seeking other sources of funds.

CLINICAL TRAINING - REASON FOR TERMINATION

Question: The budget for fiscal year 1983 eliminates all funds for clinical training in the areas of mental health, drug abuse, and alcohol abuse. At the same time, the report of the Graduate Medical Education National Advisory Committee indicates there will be a shortage of psychiatrists and other mental health care professionals over the next decade.

How do you square the proposed elimination of NIMH clinical training with the Advisory Committee report?

Answer: Our budget request is based on the proposition that the Federal government must reduce its spending, and each agency should help by initiating program cuts where it can. We have determined that our research activities are of the highest priority, and are retaining them at the expense of clinical training. While we recognize that some shortages of psychiatrists and other mental health care professionals may exist over the next decade, State and private sources should be able to continue NIMH initiatives in the mental health clinical training area.

ALTERNATE SOURCES OF FUNDING

Question: What evidence is there that clinical training will be adequately supported by other sources of funding?

Answer: The States currently devote a large share of their budget to their State Universities, and have a substantial interest in continuing those programs which are responsive to State and local needs. It is in their interest to make up that small percentage of funds which were provided by the Federal government unless the programs are deemed irrelevant to State goals. We have seen the States gradually increase funding for the agency's State Manpower Development Program, a program designed to meet State needs and essentially under State control.

MINORITY TRAINING

Question: What effect will the elimination of clinical training have on the number of minority students pursuing careers in mental health?

Answer: ADAMHA has conducted a number of clinical training programs, including the Minority Fellowship Program, which directly or indirectly support minority students in the mental health area. Federal funds represent a small portion of the overall cost of conducting these programs. While these programs will be eliminated along with all others, a training capacity has been established at minority and other institutions which we hope will in some way be continued after the termination of Federal funding. Possible sources of funds include increased State contributions and individual and private organization funding.

CLINICAL TRAINING - GERIATRIC PSYCHIATRY

Question: Meeting the special mental health needs of the elderly is becoming increasingly important, especially in view of the projected increase in the size of our elderly population over the next several years.

Do we have an adequate number of geriatric psychiatrists and geriatric mental health nurses to meet the special mental health needs of the elderly?

Answer: There are at present very few psychiatrists trained in this specialty, but to the extent demand increases we expect that the States and communities will respond.

FUTURE NIMH PLANS - GERIATRIC PSYCHIATRY

Question: What plans does the National Institute of Mental Health have for increasing the supply of trained professionals in this area?

Answer: The NIMH would not be supporting the training of new geriatric mental health specialists after the current fiscal year.

EFFECT OF TERMINATING GERIATRIC MENTAL HEALTH TRAINING

Question: What effect will the termination of the clinical training program have on the number of professionals working in geriatric mental health?

Answer: To the extent that our past institutional support has built the capacity of medical schools to train new professionals in this field, there should be little immediate impact. However, future trends in the number of geriatric mental health professionals will depend upon the degree to which States decide to become involved in supporting these programs, and upon the interest shown by medical school graduates.

STATUS OF MENTAL HEALTH

Question: What general conclusions can we draw about the trends in mental health in the U.S. over the last ten years?

Answer: Demographics have been, and will continue to be, decisive in determining trends in mental health in the U.S. We are becoming an older population and a concomitant of that changing composition of our populace is an increased number of people with senile dementia and Alzheimer's disease. At the same time, as the post World War II baby boom ages we will continue to have increased numbers of cases of schizophrenia. During the '80's and even '90's we will have increased numbers of depressions unless programs of prevention begin to make a difference. The increases it should be noted are in numbers - the prevalence of mental disorders may be increasing because more people are in some age groups and because people are living longer. We have no data to indicate that the incidence is increasing (or decreasing). But the demographics do indicate an increase in demand for care of the increased number with mental disorders.

INCIDENCE OF MENTAL DISORDERS

Question: Has the incidence of mental disorders been increasing or decreasing?

Answer: There is no evidence at this time that the incidence of mental disorders has had an increase or a decrease. Because of the changing composition of our population, numbers of people needing care for specific mental disorders may change. If we are able to continue our five site Epidemiologic Catchment Area (ECA) Program during the '80's, we will during that decade obtain the data that would enable us to know for most of the major mental disorders whether the incidence is changing.

MAJOR MENTAL DISORDERS

Question: What specific disorders pose the greatest health threat in the future?

Answer: Threat must be defined in terms of the morbidity, mortality and disability in the health domain as well as disruption of family and social functioning and the economic consequences associated with a particular disorder.

Taking the aforementioned definition of threat, we project that affective disorders, such as depression and manic depressive illness, anxiety disorders, stress-related and psychosomatic disorders, schizophrenia, and severe disorders of childhood and adolescence will continue to be significant threats to the U.S. population. Over and above these, we project increasing prevalence in mental health problems of the aged, and emotional and cognitive problems associated with the aging process as the proportion of this population increases in the overall U.S. population. With increasing social environmental changes (e.g., longer life span and decrease in family support systems and more reliance on peers), there will be the need to establish new support systems through private, local and governmental organizations and collaboration to deal with the chronic problems of this population.

We are currently witnessing and also project an increase in adolescent suicide and mental health problems such as depression. Similarly, emotional immaturity and instability have led to increasing failure to handle the stressful life changes associated with adolescence. There is evidence for both increased prevalance and incidence of such disorders in adolescent populations at present and it is likely that these will continue to rise in the near future.

POTENTIAL FOR CURE OF MAJOR MENTAL DISORDERS

Question: Which disorders have the greatest chance and the least chance of being cured over the next ten years through additional research?

Answer: In answering this question, it is important to differentiate cure from the control or amelioration of the symptoms of a disorder. Based on our present knowledge, it is important to predict what "cures" are likely to occur in the next decade, although we can speak about better control and amelioration of symptoms of disorders and the research that is necessary to bring about better prevention and treatment of these disorders.

Our current limited knowledge of the etiologic factors and mechanisms associated with many mental disorders limits our ability to devise new and more effective treatment strategies. Treatment research is complex and hampered by outstanding issues in diagnosis. Additionally, there are needed refinements in biological, behavioral and psychopathological procedures and methods. It is likely that as our current knowledge base increases we will find that many of the disorders are more chronic and complex than originally thought.

Newly emerging evidence on possible genetic transmission and familial environmental influences on the manifestation and continuation of a disorder must also be taken into account. For example, when a strong genetic link is established for a disorder, genetic counseling may reduce the magnitude of threat associated with that disorder by decreasing the transmission of the gene(s) associated with that disorder. There is already evidence of genetic components to such disorders as schizophrenia, affective disorders, anxiety disorders, and disorders of childhood such as autism. Studies of children at risk for future disorders are of paramount future importance.

Over the next ten years major breakthroughs in the treatment and rehabilitation of the more severe disorders such as mental retardation and the psychotic disorders, such as autism, schizophrenia, and some types of depressive disorders are least likely to occur. While treatment research has led to the amelioration of many of the symptoms associated with these more severe disorders such as schizophrenia, there is a great need for more research to allow full recovery and thus improve social and family functioning and economic independence. Similarly, while research has led to decreased mortality through suicide in depression, the toll that this illness takes in family and social functioning remains high.

The greatest advance is likely to occur in treatment of other affective disorders, anxiety disorders such as the phobias, stress related disorders, and problems of adolescent turmoil and adjustment to life situations.

SENILITY

Question: Wouldn't it be more efficient to centralize senility research into one Institute?

Answer: It would actually be less efficient to centralize research on senility into one Institute, from both scientific and cost effective viewpoints. There are several considerations in this regard: senility generally refers to a group of disorders with many different causes (technical language refers to senility as organic mental disorders or organic brain syndromes). Causes for senility include psychiatric disorders, neurological disorders, vascular diseases, infectious diseases, metabolic problems, tumors, and so forth. Hence, it makes best scientific sense to involve several Institutes whose established research could bring about the fastest progress around better identifying a specific cause or specific treatment or specific prevention strategy with senility. At the National Institute of Mental Health, for example, there is a long history of outstanding research on brain chemistry and brain structure in both its extramural and intramural research programs (in fact, Nobel Prizes have been awarded in these areas for National Institute of Mental Health extramural and intramural investigators); brain research is obviously of paramount importance in addressing senility. Similarly, the National Institute of Mental Health is demonstrating international leadership in research on memory drugs and techniques, also an area of central concern with senility. Cost-effective benefits of multiple Institute involvement in senility research became clear when the issue of new research building onto established methodologies is considered. Hence, in the case of the National Institute of Mental Health, drug treatment research for senility can build upon established psychopharmacologic research designs, thereby saving sizeable funds. As another example, with epidemiologic research, rather than having separate studies on senility and other mental disorders, the National Institute of Mental Health has been able to combine these investigations into the same project at considerable cost savings. It should be noted that Alzheimer's Disease is only one form of senility, but the same scientific and cost-efficient considerations outlined above apply to it as well.

In summary, then, experience to date shows that multiple Institute efforts in senility research seem to have been more efficient from both scientific as well as budgetary parameters. It would appear that efficiency could be improved more from further coordination among Institutes, rather than from a single, isolated effort.

SOCIAL RESEARCH

Question: The budget request indicates the National Institute of Mental Health is phasing down its support of certain kinds of social research that is not directly related to its mission.

Has social research made any significant contribution to our understanding of mental health in the last 10 years.

Answer: Social research findings have made great contributions to our understanding of mental health and illness. Sociologists have developed techniques to measure public opinion, to conduct surveys and to do reliable interviewing. These techniques have been adapted by epidemiologists to measure mental health status in the general population. Sociologists have studied the relationship between race, social class and individual achievement, self-concept, self-esteem and mental health, and have shown that mental illness is most prevalent among the lower socioeconomic groups. Cross cultural research done by anthropologists has shown similarities and differences in how mental illness is manifested in different cultures, as well as differences in how it is perceived and treated. Within the United States sociologists and anthropologists have contributed to our understanding of differences among the various racial and ethnic groups, differences which are necessary to understand in order to provide adequate treatment and services to the many groups within our country. Much social research has focused on family structure and family interaction as well as the role of the family in shaping the growing child. Other social research has studied the influence of the mass media, particularly television on children's mental health, achievement, aggressive behavior, etc. Communication research has led to improved psychotherapeutic techniques. Social psychologists have studied social perception, interpersonal behavior and attribution processes. These studies have helped us understand how we perceive ourselves and others. Since much psychotherapy is designed to change the client's concept of self and others, this research has contributed to the ways in which patients are treated in therapeutic situations.

SOCIAL RESEARCH TERMINATED BY NIMH

Question: What are some examples of the specific kinds of social research that will be terminated by NIMH?

Answer: Research on social conditions or problems which are not explicitly focused on mental health will be phased out. Such studies include:

- Social effects of divorce and divorce law changes.

- Assimilation and adaptation of refugees.

- Significance of values toward work.

- Laws relating to juvenile delinquency, rape, etc.

- Social and cultural factors influencing rape.

- Research on social movements or change not explicitly related to mental health.

- Cross cultural studies of life styles and values.

EXPENDITURES FOR SOCIAL RESEARCH

Question: How much did the NIMH spend in fiscal years 1980 and 1981 on the kinds of social research that is now ineligible for funding and how much is contained in the budget for fiscal year 1982 and 1983?

Answer: In FY 80 the NIMH funded approximately $10 million in social research now ineligible for funding under the new administration policy. After the President's rescission proposal on March 10, 1981, the NIMH excluded from funding approximately $3.3 million approved new and competing research grant applications.

The NIMH is no longer accepting applications for social research that is not explicitly related to mental health. It is continuing to honor commitments to projects initiated prior to March 10, 1981. Approximately $1.9 million is in the FY 1982 budget for grants which will terminated in FY 1982. In FY 1983 there will be no funds for social research not directly related to mental health or illness.

PREVENTION RESEARCH

Question: The budget for fiscal year 1983 contains $4.7 million for prevention research or approximately 3% of the total research budget. This is about the same percentage spent in fiscal year 1981.

Given the Secretary's emphasis on prevention, why is only 3% of the research budget spent on prevention research?

Answer: The $4.7 million for prevention research in the NIMH budget is for the Prevention Center of the NIMH Division of Special Mental Health Programs. This office administers projects which are substantially prevention in nature. There are additional research programs with some prevention component in other units of the Institute, such as the Institute's Center for Studies of Stress in the Workplace, the Center for Studies of Antisocial and Violent Behavior, the Aging Center, the Rape Center, the clinical programs of the Division of Extramural Research, and the epidemiology programs of the Division of Biometry and Epidemiology. When added together, these programs, in the aggregate, could bring the prevention figure up to almost 20 percent of the entire NIMH budget.

FINDINGS FROM PREVENTION RESEARCH

Question: What have we learned so far from prevention research?

Answer: Research on the prevention of mental illness and behavioral dysfuction has, until recently, been subsumed in a broad range of studies of the biological and psychosocial factors that can lead to the development of disordered functioning. This research has identified a number of significant risk factors that are associated with mental disorders. These include stressful life events, such as marital disruption, death, catastrophic events, both natural and economic, and being the offspring of severely mentally ill parents.

High risk factor studies have also identified groups who appear invulnerable to stress, leading to additional research on coping styles that mediate stress. Social support networks have been found to be particularly effective in ameliorating stressful life events.

We have learned by convening a series of workshops that there is sufficient basic research knowledge base in several areas to begin to test out early preventive interventions. As identified in workshops, these areas include: 1) Prevention of stress-related psychiatric disorders; 2) Prevention of mood disorders in adolescence; 3) Utilization of epidemiological approaches for the prevention of conduct disorders; and 4) Preventive interventions with families having a mentally ill relative.

The NIMH established an Office of Prevention in 1979 to serve to coordinate research findings on prevention.

PROJECTED ACCOMPLISHMENTS IN PREVENTION RESEARCH

Question: What do you hope to accomplish with prevention research over the next several years?

Answer: Our objectives include the reduction of the incidence and prevalence rates for specific mental disorders which arise from acute life crisis situations, stressful events, and relationships within multi-risk families. In pursuit of these objectives, we intend to develop model intervention programs which can be replicated by individual treatment systems, and take steps to bridge the gap between basic research findings and practical application of new techniques to high risk populations.

We propose to develop prevention research centers which will focus their efforts upon specific problem areas. Part of this approach is directed toward attracting high quality researchers in diverse disciplines who will concentrate their efforts on prevention techniques. This approach is being used with considerable success in our ongoing Clinical Research Centers program.

INCREASING SUPPORT FOR PREVENTION RESEARCH

Question: What is the feasibility of increasing the percentage of research dollars allocated to prevention research?

Answer: Prevention research will receive $2.4 million for new and competing grants in 1983. This amount represents our best estimate of what we anticipate will be high quality applictions coming in from the field in response to new research initiatives.

However, we will be launching a new initiative to develop Prevention Centers in select sites. If sufficient quality applications are received, we would increase the percentage of research dollars allocated to prevention research.

TREATMENT AND CURE OF DRUG ABUSE

Question: How has research funded by the National Institute on Drug Abuse contributed to the treatment and cure of drug addiction?

Answer: Research funded by the National Institute on Drug Abuse (NIDA) has contributed to significant advances in the care and treatment of drug abuse in two principal ways; through the development of more effective pharmacological treatment agents and through the development of more effective treatment delivery methodologies.

Drug abuse is perhaps best thought of as a chronic disease, similar in many ways to diabetes or alcoholism. Just as there is now no "cure" for diabetes or alcoholism, there is, as yet, no "cure" for drug abuse. The goal of treatment is to free the individual from active dependence or use of abused drugs, thus eliminating the harmful effects of drug abuse on health and enabling the individual to lead a normal life.

One of the most difficult problems in the treatment of drug abuse is the heterogeneity of the drug using population both in terms of individual characteristics and the diversity of substances used. Treatment that works for one person often proves ineffective for another. Treatment success varies depending on such diverse factors as the personality of the individual, the type of drug abused, and the history and pattern of drug use. Because of this, NIDA began a major effort to, first, delineate the pharmacological and behavioral factors contributing to continued drug use and, second, use the results of this research to identify optimal patient-treatment combinations. One result of this effort has been the development of a number of new pharmacological treatment agents suited to the needs of various kinds of opiate abusers. Another has been the development of specific treatment and intervention approaches tailored to the needs of particular groups of drug users.

At the present time, for example, NIDA is developing three pharmacological agents to assist in the treatment of opioid abuse. One, levo alpha acetyl methadol (LAAM), is a long acting methadone-like substance which needs to be administered only three times a week. This substance is sufficiently long acting to obviate the need for take-home methadone, and thus decrease the number of patient contacts with the clinic, while minimizing the risks of methadone diversion. The second, naltrexone, is a long acting narcotic antagonist which blocks the effects of opioids at the receptor sites in the brain. It has been used on several thousand patients and found to be extremely safe and well tolerated. It needs to be administered only two or three times a week. A third, buprenorphine, is a mixed narcotic antagonist-agonist. At low doses it is similiar to a narcotic, at higher doses it is similiar to naltrexone. It has been approved for use in the treatment of pain. It is being investigated for use in the detoxification and maintenance of opioid abusers.

Since its inception, NIDA has supported studies designed to explore the efficacy of drug abuse treatment provided in a representative number of drug abuse treatment programs across the country. These studies have helped to clarify the strengths and weaknesses of current drug abuse treatment modalities. They found, for example, that residential (therapeutic community) treatment programming, methadone maintenance treatment, and outpatient drug-free treatment are effective in helping patients to function free of opiate and nonopiate drugs, and to maintain themselves crime-free in the community. On the other hand, it found that methadone detoxification programs are comparatively unsuccessful.

On the basis of these findings, several initiatives have been undertaken in an effort to improve still further the functioning of drug abuse treatment programs. One initiative involves efforts to more appropriately prescribe treatment regimens for particular kinds of drug abusers. For example, many drug abusers use many substances: marijuana, alcohol, cocaine, narcotics, sedative-hypnotics and stimulants in a variety of combinations and permutations. These individuals often have concommitant personality difficulties. They may, for example, be depressed and be self-medicating to improve what they perceive as unpleasant life circumstances. It has been reported that, in these cases, treating the person's depression may decrease the probability of recidivism to both drug taking behavior and criminal or self-destructive behavior. Hence, these people are best treated by prescribing a treatment regimen which includes treatment of their depression as well as treatment of their specific drug abuse problem. In a similar effort, the Institute has also supported investigations of family therapy, which is particularly important in the treatment of the large number of comparatively youthful patients now seeking drug abuse treatment.

NIDA has also become involved in the development of programs to allow patients to be maintained in their communities, drug-free and productively so that they need not return to the already overburdened drug abuse treatment program for later support or assistance. The Institute has, for example, sponsored the use of self-help initiatives for clients who have left drug abuse treatment programs. These groups, made up of former drug abusers, are able to give to both exiting and former patients support for maintaining themselves drug-free, can give advice and assistance with regard to jobs and community living in general, and provide a new circle of drug-free friends intent on succeeding in the community. Initial findings from these projects support this inexpensive effort. This kind of treatment aftercare has been found to be effective with long-term heroin users returning to the community from treatment. NIDA has also tried to increase programs' abilities to provide clients with employment, or otherwise allow clients to be involved in productive activities. It has been found that former drug abusers are able to become productive employees, capable of obtaining jobs and generating tax revenue. For example, recent studies have shown that while, in treatment or remission, former addicts commit crimes at, on the average, only one sixth of the rate of active addicts. Thus, treatment not only aids former addicts in living more productive lives, it also greatly reduces the incidence of crime in the community.

Question: Do you foresee any breakthroughs in the near future that would substantially improve our ability to treat and cure drug addiction?

Answer: The most easily identified potential breakthroughs in the treatment of drug abusers involve the development of chemotherapeutic agents. At present, the prinicipal drugs being studied are LAAM, naltrexone, and burprenorphine. All of these drugs have significant benefits when compared to methadone, the only widely used chemotherapeutic agent for narcotic addiction. For example, they act for a longer time, which means treatment regimens using these will be less disruptive of the patient's normal life and employment activities; they are less toxic, which means they will pose less risk to patients' health; they are suitable for a wider variety of patients, which means that patients' who could not be treated with methadone may be able to be treated with one of these drugs; and treatment regimens using them should be less costly than methadone maintanence.

Non-pharmacological breakthroughs in treatment come very slowly and are more difficult to predict. Important advances are being made in better understanding factors contributing to the development of drug abuse, identification of the determinants of high abuse liability of specific substances, and how behavioral patterns can be altered to foster the development of a more productive individual. These range from basic research into the mechanisms of drug abuse to applied research into the delivery of drug abuse services. For example, the Institute is now sponsoring research to determine whether some forms of narcotic abuse are the result of deficienies in the body's production or use of its own endogenous opiate-like substances in much the same way that diabetes is the result of deficiencies in the body's production of insulin. This research is an outgrowth of previous NIDA sponsored basic research which resulted in the discover of opiate receptors in the central nervous and associated endogenous opiate-like substances, endorphins and enkephalins. The eventual payoff of this research could be the development of an insulin like treatment for drug abuse. The Institute is also sponsoring research aimed at finding ways of better delivering drug abuse treatment services. This research has pointed to the importance of dealing with all aspects of the patient's life in drug abuse treatment. The refinement of specialized treatment approaches such as family therapy and vocational rehabilitation hold considerable promise for increasing the overall effectiveness of drug abuse treatment. Also promising are efforts to refine diagnostic and treatment planning skills to identify which combination of treatment approaches are most effective for specific patient populations. This research will eventually make it possible to more appropriately prescribe treatment regimens based on the needs of individual patients.

Question: How do you account for the substantial increase in the rate of cocaine use in the United States?

Answer: The substantial increase in cocaine use in the United States can be attributed to three factors. First, the availabilty of cocaine has dramatically increased. This increase is, at least in part, in response to an increased demand for the drug. Availability itself, however, is a factor contributing to drug use. Second, an inordinate amount of publicity has contributed to the widespread knowledge about the drug and its "desirability" in terms of social status and other factors. The considerable press coverage that has been given to the use of cocaine has, at least in part, contributed to the demand. Third, the drug is indeed an effective biological reinforcer which enhances social and other activities in a fashion at least immediately desirable to the user, potential long term dangers notwithstanding. This inherent characteristic combined with social factors and the availability of cocaine is responsible for the current widespread use and demand.

It should also be pointed out, however, that there are some indications that the rapid increase in the use of cocaine is beginning to level off. Between 1976 and 1979 the proportion of high school seniors using cocaine during the prior year doubled, from six percent to twelve percent. Since then the statistic has increased by only 0.4 percent.

Question What research does NIDA have underway regarding the effects of cocaine?

Answer: The Institute has implemented a broad spectrum of projects investigating all aspects of cocaine abuse. NIDA is currently funding 18 major and minor projects, at a cost of approximately $600,000, investigating the health effects of cocaine. These studies involve the analysis of diverse aspects of the effects of cocaine, its precursors and metabolites. Investigations are being carried out in biochemistry, neurological function, behavioral genetics, behavioral and psychopharmacology, pharmacology, pharmacokinetics and pharmacodynamics and in the area of assay development for purposes of screening and detection. New studies will investigate why approximately ten percent of the people who use cocaine recreationally go on to compulsive use.

ALCOHOLISM RESEARCH

Question: How has research funded by the National Institute on Alcohol Abuse and Alcoholism contributed to treatment and the recovery of alcoholics?

Answer: The ultimate aim of all research is to provide a useful base of information for the development of more effective treatment and preventive approaches. Research efforts supported by the NIAAA have proved helpful in the development of more effective and cost-efficient treatments in the area of alcoholism per se as well as the medical disorders consequent to alcohol use. For example, NIAAA research grants in the 1970's established that alcohol itself, even in the presence of an extremely nutritious diet, can cause alcoholic cirrhosis, a frequently fatal liver disease that requires lengthy and recurring hospitalizations. This finding represents a total reversal of the public health attitude of the medical community in the 1940's, 50's, and 60's, which had considered cirrhosis to arise from the restricted diets of alcoholics and not from the toxic actions of alcohol. As a result of this research, physicians now advise heavy drinkers of the risk for serious liver disease, in contrast to the earlier and ineffective practice of encouraging an increase in nutrient intake without alcohol reduction.

Research findings have also been useful in suggesting the appropriate medical procedures to be employed during detoxification and in the emergency room handling of acutely intoxicated persons. Such information includes the finding that alcoholics in emergency room situations may actually be hydrated and not dehydrated as previously thought; evidence questioning the practice of prescribing dilantin in the routine treatment of withdrawal; and recognition that intravenous fluids might precipitate congestive heart failure for the average patient. Changes in medical procedures resulting from these findings have contributed to a reduction in the medical complications and hospitalizations that otherwise accompanied these situations.

Progress is also now being made in the development of diagnostic techniques that can aid in the early identification of alcohol-related problems. One particularly promising approach entails the use of blood samples to develop analytic profiles that can reliably distinguish individuals who have drinking problems from those who do not. The approach has also shown promise as a noninvasive alternative to surgical procedures for differentiating between alcoholic and nonalcoholic liver disease. Since this technique relies upon routinely requested blood work that is obtained during regular physical examinations, it offers promise as an effective and economical procedure to aid physicians in arriving at a medical diagnosis and developing an appropriate treatment plan.

Question: What evidence is there to show that our ability to treat alcoholism has improved over the past five years?

Answer: Advances have been made over the past five years in developing methods of treatment for alcoholism as well as for other alcohol-related illness. There is also evidence that more people are seeking treatment than was the case five years ago. Information from the National Drug and Alcoholism Treatment Utilization Survey shows that the number of persons treated in 1980 was five percent greater than the number treated in 1979.

Although there are a variety of treatment modalities now being used effectively, there is little knowledge as to why one treatment method works for one patient and not for another. In this respect, treatment research is just beginning. Great strides have been made in patient identification, establishment of diagnosis and recognition of subtypes of alcoholics. This represents the first step in the very complex process of investigating the relative efficacy of the various treatment modalities.

Significant advances have been made in recent years in occupational programming. Programs for troubled employees, in which the alcoholic is identified and referred to treatment, have doubled since 1977 and now more than 5,000 programs cover 10.5 million U.S. workers. Treatment programs consistently report that treatment outcome is significantly better for employed patients referred from the workplace. We have also learned that the concept of occupational programming can be transferred successfully to schools, health care institutions and highway safety efforts.

Advances have also been made over the past five years in introducing educational programs on the recognition and treatment of alcoholism into the curriculum of medical schools. This has improved the capability of the health care system in treating persons with alcohol problems. Research has established that alcohol is a factor in a wide range of medical disorders including diseases of the heart, the gastrointestinal system and the liver. This information has been significant in alerting physicians to the dangers of alcohol abuse among their patients at risk for these diseases and in facilitating their treatment.

Although progress is being made in our ability to treat individuals with alcohol problems, much remains to be learned about the treatment of these disorders. Treatment research will be emphasized in 1983 focusing on the development of improved treatment techniques and methods of assessing new and existing treatment procedures.

Question: What gains have been made in research into understanding what causes this disease?

Answer: A significant body of data has been accumulated indicating that genetics play an important, though not necessarily a singular role in alcoholism predisposition and susceptibility. Several twin studies have been conducted comparing various aspects of drinking among identical twins and fraternal twins. These studies reported that concordance rate for alcohol abuse among identical twins was twice that observed among fraternal twins. Frequency, quantity of drinking as well as response to alcohol were also more similar among identical twins. These findings strongly suggested a genetic influence on the drinking outcome since identical twins share the same gene expressions and environment while fraternal twins share a similar environment but differ in half of their genes. Recent adoption studies have shown that sons of alcoholic fathers were four times more likely to be alcoholic than sons of nonalcoholic fathers, whether raised by nonalcoholic foster parents or by their biological parents. Furthermore, grandsons of alcoholics are reported to be three times more likely to develop alcoholism than the general male population. Insufficient data is currently available to substantiate a genetic factor in alcohol transmission among women.

Research is being conducted to identify the specific heritable traits that underlie the genetic transmission of alcoholism. Studies on individual differences in alcohol metabolism have shown that alcohol dehydrogenase and aldehyde dehydrogenase, the two enzymes responsible for alcohol metabolism, exist in many distinct forms called "isoenzymes." The number and content of isoenzymes in each individual appear to vary according to genetic background. It has been suggested that differences in the prevalence of alcoholism among different racial groups may be at least partially accounted for by innate differences in rates or pathway of alcohol metabolism.

A number of studies reported that acetaldehyde, a primary metabolite of alcohol, reacts with neuroamines to form a group of beta-carboline tetraisoquinoline (TIQ) derivatives. These derivatives are biologically active and are believed to be responsible for the development of intoxication tolerance dependence, and neuronal damage. It is postulated that the level of TIQ is significantly higher in individuals who are susceptible to alcoholism.

Other studies on behavioral predisposition revealed that during childhood and youth, future alcoholics are typically impulsive and rebellious. Most of them have difficulties in dealing with and overcoming depression, frustration and anxiety. These personality characteristics in early adulthood may be related to subsequent development of alcoholism.

These represent only a few inroads that research has begun to make into the understanding of what causes alcoholism. There are still many unanswered questions.

Question: What gains have been made in identifying those persons susceptible to this disease?

Answer: Again, research in the field of alcoholism is in its infancy. The potential for major research breakthroughs which will reduce the economic, as well as the non-economic, cost to alcoholics, their families and friends are great. Let me just mention a few of our gains. Alcoholism seems to run in families. The chance of an individual developing this disorder appears to be directly related to the number of family members who are alcoholic and the severity of their illness. Studies of twins and adoptees previously described suggest that there is a genetic component at least in some forms of alcoholism. High risk individuals may be identified through careful investigation of family history for alcoholism. Clues for alcohol predisposition may also be obtained from observation of personality characteristics or psychiatric disorders common for alcoholics.

Research is being conducted to identify genetic markers for alcoholism. One study reported that young men who have a family history of alcoholism appear to react differently to alcohol than do young men without a family history of alcoholism. In addition to differences observed in motor and cognitive tests, men with a family history of alcoholism appear to form a higher level of acetaldehyde than men without a family history of alcoholism after alcohol ingestion. Deficits in electrophysiological measures such as evoked brain potentials were also observed in prealcoholic children having a positive family history of alcoholism after alcohol ingestion. Such findings, when further developed and refined, will be of great utility for identifying high risk individuals.

Question: Do you forsee any breakthroughs in the near future that would substantially improve our ability to treat alcoholism?

Answer: Yes, we are doing research which attempts to develop a model for identifying and analyzing antecedent determinants for relapse among treated alcoholics which has major implications for development of treatment and post-treatment programs. Little is known about alcoholic relapse, and current literature largely reflects what has been based on retrospective self-reports by alcoholics. The current study is a pilot project which has potential for providing valuable information regarding relapse in alcoholic patients, a problem of major significance in the treatment of alcoholism. Once clearly identified, knowledge of factors which put the patient at risk for relapse could facilitate design and implementation of alcoholism treatment strategies with enhanced long-range positive prognosis probability.

The relationship between affective disorders and alcoholism has been the subject of controversy focused on the frequency of primary and secondary affective disorders coexisting with alcoholism. Information from a clinical study to evaluate the efficacy of lithium in treatment of alcoholism, may lead to a breakthrough by providing definitive information regarding this agent and its positive or negative indications for continued use. The study is also expected to yield extensive information on incidence and prevalence of affective disorders and alcoholism within families of alcoholics. Very early trends observed in a limited number of subjects indicate a higher than anticipated incidence of previously undetected renal dysfunction. Existence of renal pathology if substantiated in alcoholic populations would pose serious questions regarding the current clinical trend to use lithium in alcoholism treatment. This concern becomes heightened with increased reports of renal damage resulting from lithium administration. From data analyzed for the first 33 subjects taken into the study, age of onset of alcoholism has been indicative of high incidence of early alcoholism; onset for 24 patients before age 25 and for 8 patients prior to 18. Should such findings continue and be verified implications for redefining "alcoholism," "heavy drinking" and other terms in clinical use may result. Such findings would continue to emphasize the need for development of early identification and screening methods.

Clinical use of disulfiram in alcoholism therapy is widespread. An ongoing study assesses the pharmacokinetics and associated pathological consequences of long-term disulfiram use. Findings here will have particular relevance to the practice of sustained and continuous use of the agent by patients whose alcoholism is diagnosed and therapy utilizing disulfiram is begun at a young age. Findings may prove that disulfiram is contraindicated in a large number of patients if they receive adequate medical screening.

Another potential breakthrough is the development of a methodology for administration of slow release disulfiram infusion.

Such therapy would be appropriate for hard-core, difficult to treat cases in which compliance is a compounding problem. The stage of development is early but current efforts indicate that establishment of a dose level for obtaining disulfiram-ethanol response is possible. Such therapy could add to the physician's armamentarium of presently limited techniques for hard-core cases of alcoholism.

ADAMHA DEMONSTRATION PROGRAMS

Question: The Omnibus Reconciliation Act continued a demonstration program for developing new and more effective alcohol and drug abuse prevention, treatment, and rehabilitation programs. The Act authorized $30 million in fiscal year 1982 although no funds were requested. Does the Administration have any plans for requesting a re-authorization of this program in fiscal year 1983 or in subsequent years?

Answer: The Administration does not intend to request a reauthorization of the categorical demonstration authorities for developing new and more effective alcohol and drug abuse prevention, treatment, and rehabilitation programs. We do believe that such programs are important, but see the bulk of these activities conducted by the States under authority of the block grants. Necessary select activities in this area may be conducted within the ADAMHA research program.

Question: If no funds are to be requested, how will the objectives of the legislation be met?

Answer: As noted above, the objectives of the separate alcohol and drug abuse prevention, treatment, and rehabilitation demonstration program authorities can be met through State activities under the block grant and, to the extent necessary, the broad research authority of Section 301 of the Public Health Service Act.

BLOCK GRANT ADMINISTRATION

Question: We have been most concerned that the States implementing the block grants will use the funds to maintain layers of local administration at the expense of cutting back on providers and essential services. What are you doing to prevent such a development?

Answer: The Alcohol and Drug Abuse and Mental Health Services Block Grant legislation states that each State may use not more than 10 percent of its block grant funds for administrative purposes. While the law does not preclude the local service providers which receive these funds from the States from using them for their costs of administration, we feel confident that the States will, in fulfilling their responsibility to make funding determinations, choose those projects which show most promise of meeting State need and will not support administration at the expense of essential services. The Department will, as required by statute, be reviewing annual reports submitted by the States on their activities under the block grant to assure that funds are spent in accordance with the law and consistent with needs identified by the States.

Question: What instructions, if any, do you give the States to prevent the bureaucrats from taking away service and provider money?

Answer: Consistent with the block grant legislation which vests the responsibility for funding decisions at the State level, the Department has made it clear that the States are responsible for interpretation of the various provisions of the statute and that, unless an interpretation is clearly erroneous, the Department will not interfere with a State's decision. We agree with the philosophy underlying the block grant legislation that the States are best capable of deciding what their needs are and how these needs should be addressed.

Question: What report or bill language would assure that money for services is maximized--and money for overhead is minimized?

Answer: We think is is premature at this time to suggest amended statutory or report language because it is not yet clear whether a problem exists that needs to be corrected. As mentioned above, not more than 10 percent of the block grant is to be used for its administration. At this time we simply do not know whether fears that too many State dollars will be used for administration, not services, will prove accurate. It is appropriate to await the completion of a full funding cycle and to hear from the States and local communities about how the law has worked before suggesting that the States are acting irresponsibly.

NATIONAL ALCOHOL COMMISSION

Question: What is the status of the National Commission on Alcohol Abuse and Alcoholism?

Answer: The National Commission on Alcoholism and Other Alcohol-Related Problems is currently inactive. The Commission was established by P.L. 96-180 in January, 1980 with an authorized level of $1 million. The authorization is to remain in effect for 2 years subsequent to the appropriation of funds. The Commission Charter was signed in August, 1980 and its members, appointed by the House, by the Senate and by the President were sworn in at the Commission's only meeting in December 1980. However, the Commission has undertaken no activities in support of its mandate because funds for this purpose have not been appropriated.

Question: What should be the Federal role in development and dissemination of model programming in both alcohol and drug abuse treatment and prevention to the States?

Answer: As the States assume responsibility for managing the delivery of drug abuse and alcoholism treatment and prevention services, we anticipate that they will increasingly undertake service demonstrations similar to those conducted under the former categorical programs. The direct ADAMHA role in developing model programs will be limited to research demonstrations, especially projects of major national significance. Examples of this include a tightly controlled drug abuse study of the effectiveness of a school-based prevention program. This project has provided clear evidence about which prevention components actually work. Another project is one jointly sponsored by ADAMHA and the Health Care Financing Administration to test the provision of alcohol treatment in lower-cost settings for Medicare and Medicaid recipients.

While the States will have the lead in conducting prevention and treatment demonstrations, dissemination of the results to interested parties nationwide will be a major part of our national role. New knowledge will be relayed to States, local communities, private organizations, and anyone working in the drug abuse and alcoholism areas. This will help ensure that new knowledge is actually used in developing more effective treatment and prevention programs. When requested, NIDA and NIAAA will provide direct technical assistance to entities attempting to improve the quality and effectiveness of their programs.

Question: How are the Alcohol and Drug Abuse Institutes cooperating with and sharing their expertise with other agencies in the government attempting to address the problems of alcohol, drug abuse and mental illness (e.g., ACTION and the Department of Defense)? How can this interaction be improved upon to ensure that the most effective use of resources is achieved?

Answer: NIDA is actively involved in approximately fifty interagency cooperative programs throughout the federal government including ACTION, the Department of Defense, various institutes of the National Institutes of Health, the Food and Drug Administration, the Federal Bureau of Prisons, the Department of State, the Health Services Administration, the Federal Courts, the Department of Justice, the U.S. Post Office, the Office of Education, and the Center for Disease Control.

NIDA is working with ACTION in the area of drug abuse prevention. ACTION is distributing many of NIDA's publications and NIDA has prepared a special publication for ACTION. NIDA and ACTION developed a proposal, which is now being implemented, for a model national drug abuse prevention program for the General Federation of Womens's Clubs. NIDA cooperates with the development of a media program on drug abuse for the Navy, training of drug abuse treatment workers, and the evaluation of emerging or controversial health care technologies.

The primary mechanism through which NIAAA coordinates with other government departments and agencies attempting to address issues related to alcohol abuse and alcoholism is the Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism. The Interagency Committee, established by P.L. 93-282 in 1974, is mandated among other things, to provide for the communication and exchange of information necessary to maintain the coordination and effectiveness of Federal programs and activities which relate to alcohol abuse and alcoholism; and to seek to coordinate efforts undertaken to deal with alcohol abuse and alcoholism in carrying out Federal health, welfare, rehabilitation, highway safety law enforcement, and economic opportunity laws.

The Director of NIAAA serves as Committee Chairperson on behalf of the Secretary, DHHS. The Committee's Executive Secretary is also an NIAAA staff person. Other DHHS representation includes the

Public Health Service and the Office of the Secretary. Member departments and agencies include Department of Defense (DOD), Department of Transportation (DOT), Veterans Administration (VA), Department of Treasury and ACTION. Five public members appointed by the Secretary, DHHS are also included.

NIAAA is also participating in a number of collaborative efforts with other governmental components. For example, one project with the National Heart, Lung and Blood Institute, supports research on alcohol induced heart muscle diseases; another collaborative effort with the National Cancer Institute, NIH, seeks to enhance research activities in the area of alcohol and cancer. Collaborative efforts with the VA include a collaborative study to determine the consequences of alcohol abuse on brain functioning and subsequent improvement with abstinence. With DOD, NIAAA is participating in joint studies to develop therapeutic agents for the treatment of alcohol withdrawal syndrome, and to develop an inexpensive diagnostic technique for the early identification of problem drinkers by examination of routine blood chemistries.

We feel that interagency coordination in the drug abuse and alcohol areas is working extremely well, and that no improvement is necessary at the present time. Overlap of programs funded is at a minimum and activities of the different agencies are in most cases supportive of one another. Resources are being used effectively through the joint funding of individual projects, where appropriate, and the sharing of information regarding research findings when supported by a single Federal agency.

NATIONAL SUPPORT FOR CLINICAL TRAINING

Question: You have stated that the Federal Government provides only 5% of the ADM clinical training funds nationally. Can you provide a breakdown of where the other 95% comes from?

Answer: The 5% figure represents our best professional estimate given a numeral of very complicted variables. The funding of clinical training programs is a complicated matter and varies widely from department to department even in the same discipline. Major sources of support include student tuition and fees, endowment funds or State support (in public universities) and, especially for psychiatry, fees for services rendered to patients. I would like to make it clear that the 5 percent figure referred only to Alcohol, Drug Abuse, and Mental Health clinical training grants, not to funding through other programs of the Federal Government.

SUBCOMMITTEE RECESS

Senator ABDNOR. The subcommittee will now recess until Friday, March 5, at 2 p.m. to discuss appropriations for the Office of Human Development Services and Departmental Management for the Department of Health and Human Services.

We stand in recess.

[Whereupon, at 10:40 a.m., Wednesday, March 3, the subcommittee was recessed, to reconvene at 2 p.m., Friday, March 5.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

FRIDAY, MARCH 12, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:03 a.m. in room 1224, Everett McKinley Dirksen Senate Office Building, Hon. Harrison H. Schmitt (chairman) presiding.

Present: Senator Schmitt.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES ADMINISTRATION

STATEMENT OF ROBERT GRAHAM, ACTING ADMINISTRATOR

ACCOMPANIED BY:
- ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET
- JAMES A. WALSH, ASSOCIATE ADMINISTRATOR FOR OPERATIONS AND MANAGEMENT
- FLORENCE B. FIORI, DIRECTOR, BUREAU OF HEALTH FACILITIES
- THOMAS D. HATCH, DIRECTOR, BUREAU OF HEALTH PROFESSIONS
- WILLIAM BERRY, ACTING DIRECTOR, BUREAU OF HEALTH PLANNING
- CLAY SIMPSON, ASSOCIATE ADMINISTRATOR FOR HEALTH RESOURCES OPPORTUNITY PROGRAMS

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The hearing will come to order.

This morning we will continue our regular fiscal year 1983 appropriations hearing for the Labor, Health and Human Services, and Education appropriations bill.

This testimony today will be from the Health Resources Administration and Dr. Robert Graham, who is the Acting Administrator.

Dr. Graham, please introduce your people that have joined you today and then proceed with your statement. I will then proceed with questions.

INTRODUCTION OF ASSOCIATES

Dr. GRAHAM. Thank you, Mr. Chairman.

At the table with me to my right is Mr. Tony Itteilag, who is the Deputy Assistant Secretary for Budget with the Department; to my left is Dr. James Walsh, who is the Associate Administrator for Management and Operations of the agency; immediately behind me, from your right, is Dr. Clay Simpson, the Director of the Office of Health Resources Opportunity; Mr. Thomas Hatch, Director of the Bureau of Health Professions; Dr. Florence Fiori, Director of the Bureau of Health Facilities; and Mr. William Berry, Acting Director, Bureau of Health Planning.

PREPARED STATEMENT

If I could, Mr. Chairman, I would like to submit my prepared statement for the record at this point and just summarize briefly with an overview of the agency in fiscal year 1983.

[The statement follows:]

STATEMENT OF ROBERT GRAHAM

I am pleased to appear before the Committee to present a proposed Health Resources Administration fiscal year 1983 budget amounting to $136,411,000 and 453 positions. Included in this request are funds to continue the phase-out of Federal support for Health Planning and to carry out a range of activities in the area of health facilities. Also included in this request are monies to administer the health professions portion of the Omnibus Budget Reconciliation Act of 1981 which extended the health professions and nursing authorities through 1984, and funds for general support.

Health Planning

In fiscal year 1983, no funds are requested for grants to State or local health planning agencies. To the extent that States or communities wish to continue their health planning efforts, they are encouraged to do so with their own funds.

For the health planning program, the focus during fiscal years 1982 and 1983 is to effect an orderly phase-out of Federal support of health planning. In 1982, funds are being directed to those local planning agencies with a demonstrated record of effectiveness and a proven capacity to continue planning activities in the absence of Federal financial support in communities that want health planning services.

The request for this program is $2,083,000 and 14 positions to phase-out Federal support for health planning.

Health Facilities

The Bureau of Health Facilities was established to promote the effective utilization of existing health facilities, to direct programs relating to health facilities modernization and construction, and to safeguard the government's interest by ensuring the viability of a combined DHHS and HUD loan portfolio of approximately $3.3 billion.

In 1983, resources will be used (1) to monitor outstanding health facility loans and loan guarantees in order to minimize Federal default liability; (2) to monitor health facility construction grants, recovering Federal funds where required; (3) to ensure that those facilities that previously received Federal funding comply with requirements to provide a reasonable level of uncompensated care to persons unable to pay; (4) to administer a program designed to promote energy conservation and cost savings by health facilities; (5) to assist in the development of Department policy in the area of health facility planning and capital formation; and (6) to pay interest subsidies on construction loans for five health professions teaching facilities and to make payments of interest and principal for one of the five guaranteed loans that defaulted under the loan guarantee provision.

The budget request for this Bureau is $8,613,000 and 149 positions. In addition, we are requesting $32 million to pay interest subsidies on 282 guaranteed loans and to make payments on five loan defaults under the Title VI --Hill-Burton--guaranteed loan program.

Health Professions

The Health Professions Educational Assistance Act of 1976 and the Nurse Training Amendments of 1979 were extended through fiscal year 1984 under the Omnibus Reconciliation Act of 1981.

The 1983 request for health professions education activities is $108,492,000 for grant and contract programs, 200 positions, and $9,023,000 for program support. The Budget Reconciliation Act is aimed at addressing the broad issues of geographic and specialty maldistribution.

The Act established priorities for continued funding of health professions efforts. These include objectives and programs designed to:

-- Promote a sufficient supply of primary care health professionals relative to other types of specialties.

-- Assist in assuring the availability of health professionals in underserved areas.

-- Aid disadvantaged individuals in choosing and pursuing a health professions career.
-- Improve the utilization and distribution of nurses and increase the number providing bedside care.
— Promote National health care priorities through highly targeted special projects.
-- For National policy purposes, continue to analyze current trends in the supply and requirements of health professionals and continue the designation of shortage areas for such professionals.
-- Improve the health status for all Americans through health promotion and disease prevention activities.

The first objective of promoting a sufficient supply of primary care professionals is addressed in 1983 by highly targeted support to specialty training and residency programs in family medicine, general internal medicine and pediatrics, and development of family medicine departments in institutions training medical personnel.

The second major objective is to fund specialized programs that help assure the availability of health professionals in underserved areas. A major program directed at this objective is the area health education center (AHEC) program which provides remote site training for medical and other health professions students in medically underserved areas, and improves coordination with existing resources, including institutions, within these areas. The funding request for the nurse practitioner and physician assistant programs also contributes toward achieving the objective of providing additional health professionals for underserved areas, since studies show that the majority of these practitioners tend to locate in such shortage areas. Special initiatives in remote site training, podiatry, and continuing education will also enhance the availability of health professionals in shortage areas.

A third major objective is to aid disadvantaged individuals in choosing and pursuing a health professions career. Continued funding for the disadvantaged assistance program in 1983 will emphasize involving the health professions schools in coordinating efforts to enlarge the minority applicant pool and to foster, among these schools, a commitment to increasing minority enrollments. Support of the financial distress program in 1983 will preserve National resources for training minorities in health professions disciplines.

The fourth major objective is in the area of nursing. National priorities are directed toward problems of improved utilization and distribution of nurses and of increasing the numbers of nurses providing bedside care. While there is an acknowledged problem with shortages of nurses in certain work settings and locations, the availability of target funds will assist training institutions and hospitals to develop innovative solutions.

The fifth major objective is to promote National health care priorities through the development and implementation of highly targeted special projects. The 1983 budget request supports newly authorized special initiatives through the Curriculum Development program. This program will address veterinary medicine special projects and allied health training in disease prevention and health promotion, as well as the special initiatives, previously mentioned, addressing the availability of podiatrists and other health practitioners in underserved areas. Other areas being addressed include developing innovative techniques to help meet the needs of high risk target groups, especially the elderly, children, and pregnant women; emphasizing primary care and prevention; and providing training to enhance clinical nursing skills including concentrating on the needs of target groups in high risk categories.

The sixth major objective is to support programs that address the area of health promotion and disease prevention. Programs in public health will provide support in this area. Also, the preventive medicine residencies program will develop a cadre of preventive specialists needed to provide more general health care for the people. Finally, the special initiative projects in curriculum development for allied health will address training in disease prevention and health promotion.

The seventh major objective is to continue the program of health professions analysis and reports. The intent is to provide accurate and timely information on the Nation's health professions supply, distribution and requirements, to permit the development and evaluation of sound National health policies. This is an intramural labor-intensive program which identifies geographic and specialty distribution problems, designates health manpower shortage areas, and conducts the targeted analyses needed to answer significant questions associated with current and anticipated health policy issues.

The budget request for the health professions programs is $117,515,000 and 200 positions.

The Program Management request for $8,200,000 and 90 positions provides funds for the HRA Acting Administrator and his office and staff personnel. This includes leadership and support for short and long-range program planning, evaluation, and policy coordination, management of personnel, finance procurement, and data operations.

Thank you for providing me with the opportunity to summarize the Health Resources Administration's budget request. Mr. Chairman, and members of the Committee, I will be pleased to answer any questions you may have on the specifics of this budget request.

HIGH-PRIORITY PROGRAMS

Dr. GRAHAM. What we will be attempting to accomplish during that fiscal year will be continuation of support for high-priority programs in the health professions area, such as primary care, health professions redistribution, disadvantaged assistance, and information development and analysis.

In the health facilities area we will continue with our responsibilities which we share with the Department of HUD, in providing loan guarantees and loan insurance to institutions which seek that assistance from the Federal Government.

We will also continue our responsibilities under the free care assurance portion of title VI to assure that those hospitals which have received Federal funds in the past meet their commitments to provide public service.

In the area of health planning, we will continue the phaseout of that program and anticipate that in fiscal year 1983, as per the plan which has been presented, we will close out all Federal activity in health planning.

With that overview, sir, I would be happy to respond to any questions that you might have.

COMPETITION AND HEALTH CARE SERVICES

Senator SCHMITT. Well, thank you, sir.

I think, to begin with, I have just a general statement to let you know my discomfort with the administration's continued indiscriminate use of the expression "competition" in providing for health care services. I don't think you can so blithely use the principles of competition that come from the private business sector as a criteria for cutting out certain activities on the part of the Federal Government, or any government. There is no competition in a rural health situation, none whatsoever.

There also is the problem of competition moving into an urban situation, providing health services, skimming off the cream, if you will, of health services for those that can afford services in the county hospital or municipal hospital, and then having to take care of those who cannot afford health services.

It is not as simple as the administration seems to be articulating, the issue of competition. I am not saying there can't be some competition, but it is not nearly as simple as I have gotten the impression the administration feels it should be and can be.

If you have any comments on that, I would like to hear them. But I am quite disappointed in the overemphasis of that word in the justification that the administration provides for deleting health planning, for example, and certain health facilities activities.

Dr. GRAHAM. I think I would comment only briefly, because the development of the competition proposal within the administration and the Department is not something for which I am directly responsible. Insofar as it does relate to the health planning program and as reflected in our justification for this course of action, I would point out that one of the major rationales that is provided for our discontinuation of the health planning program is the feeling that this is an inappropriate role for the Federal Government to play by regulation, and the recognition that some States and localities may, for themselves, decide to continue health planning, either at the local or the State level, and that can and may well have a role to play under whatever procompetitive legislation is considered and passed by the Congress.

Our informal understanding at the present time is that even without continued Federal support for health planning in fiscal year 1983, there will still be 30 to 35 States that will maintain their own certificate of need programs although they may alter or change those laws to better suit local circumstances; and that for the local planning bodies, the health systems agencies, there may be a continuation in fiscal year 1983, even without Federal support, of somewhere around 40 to 50 percent of those agencies.

Now, the final outcome for the local agencies, I think, will depend very heavily upon their ability to find non-Federal funds, whether that be private funding, working with hospital and provider coalitions, or business coalitions. That is something they are addressing right now.

I agree with you very much that the competition issue is a very complex one. It is an issue, I think, where we are only seeing the early parts of the debate about how the system will work or should work. But I am not sure that the planning activities as a structure, even though not federalized after fiscal year 1982, will necessarily not be a participant in a more competitive health care system.

HEALTH SYSTEMS AGENCIES

Senator SCHMITT. What is going to take the place of the HSA's then in this interim period while we debate competition—where HSA's have been beneficial but no other source of funds appears?

Dr. GRAHAM. I think it depends on what specific function or activity you have the greatest concern about as it relates to the HSA function. I think in most people's minds, when you talk about health planning and you talk about HSA's, you think of the resource control aspect of the HSA and their participation in certificate of need activities.

Certificate of need laws are State laws. Nothing that we are doing will change the fact that these laws are on the State books, except maybe in one or two States where there is a trigger in the State's provision that would have that law go out of effect when the Federal funding expires.

So if the point of your question is what will happen as it relates to certificate of need without this Federal funding, I think in fiscal year 1983 we will see relatively little change. If the point of your question is more on the plan development and the grass roots constituency sorting out what should be the proper priorities for the development of the health care system in the local areas, then I think there is a little more uncertainty on that.

I had the opportunity early this week to meet with representatives of large numbers of the health systems agencies from around the country as they met here in Washington, and it is fairly clear to me, from the conversations with them, that in some areas there will be a continuation of local planning based upon non-Federal funds. And again, that may be funding by business coalitions. In some States there is even conversation about State funding of it, but no States have officially gone on record as saying they are going to do that.

In other areas, there may be the feeling locally that the benefits from the health systems agency are not or have not been of such a magnitude to justify continued local expenditure. In those areas it may well be that the HSA's function will die out, at least for the present period of time.

Senator SCHMITT. Well, that is what my concern is. You may have the laws on the books, but if they are not being implemented to allow some realistic way of evaluating the need at the local level, then this problem of private clinical facilities developing which skim the cream off the health care business remains, leaving the counties without any base to support the necessary nonprofitmaking provision of hospital and other health care activities. I just right now don't think that you have thought this thing through to the point where you can tell the Congress what is going to happen.

I am not saying that we shouldn't be moving toward a different environment, but its transition period is liable to be traumatic, and you are going to end up with a lot of county and municipal hospitals in serious, serious trouble.

Dr. GRAHAM. Well, I think, again, since I am not heavily involved in the discussions dealing with the development of the competition bill in the Department, and since that has not been submitted to the Congress, it is a little difficult for me to debate the nuances with you.

MAINTAINING HEALTH PLANNING

Senator SCHMITT. It is a nuance that your budget addresses, and you have been told apparently to cut these things without the administration or anybody else having a coherent plan about how it is all going to happen. And what we have to do—it is not just me; it's everyone else out there. With rising health care costs and trying to keep a lid on the development of facilities, trying to keep county and municipal hospitals, nonprofit hospitals and institutions in business, we don't see how this thing is going to work. At least in transition we don't see how it is going to work, and if we fail to get through the transition period in reasonably good shape, then the rest of it is going to fail.

What incentive will the States have for maintaining health planning if we proceed with the administration's proposal that the Feds pick up all medicaid expenses and management of that system?

Dr. GRAHAM. It would seem to me that one of the incentives is exactly what you have just outlined in your concerns, and that is the balance of services in a given State between public and private sectors, not-for-profit and proprietary. I believe that the States are responsible entities. It will not surprise me if each of the 50 or so different instrumentalities may go about it in a different way.

Clearly, if there is a switch from our present basis of sharing medicaid costs, some of the immediate incentives on the part of the States for cost containment will be removed, but those Governors and county commissioners and mayors and representatives are still going to be accountable to their citizens and to their constituencies to assure that there is proper access to services. I just can't believe that if the Federal Government has full responsibility for titles XVIII and XIX that suddenly the States aren't going to be concerned at all about the distribution of services.

HEALTH CARE DELIVERY

Senator SCHMITT. One problem we already have in many States, if not most, is that the people in the last two decades have gotten used to looking to Washington for a solution to their problems. If medicaid responsibility goes totally to the Federal Government, I am not sure that the idealized world of responsibility you just described is going to hold.

I think people are going to put pressure on Washington rather than on their States in order to solve the basic problems of health care delivery.

Dr. GRAHAM. Should that come to pass, when pressure gets put on Washington, Washington does respond.

Senator SCHMITT. Yes, but at much higher cost of the total system. That's the problem.

Dr. GRAHAM. I think, though, that what we are discussing is a perception and some anticipation of what the transition may be and whether or not the States indeed can be assumed to be responsible partners; and I believe that it is very clear on the part of the President that he feels that the States can be counted upon to be responsible partners, not only in relation to the new federalism plan and block grants, but in the area of competition in the health care field.

ADMINISTRATION OF MEDICAID

Senator SCHMITT. I agree with the President. But I also believe there have to be incentives. That's the way the system works. You talk about competition. Competition works when there are incentives. If you remove all the incentives and all the need for the State officials to concentrate on keeping medicaid costs down, they are going to go off and work on other problems. So they say, "that's the Federal Government's responsibility. Go talk to your Senator. Go talk to your Congressman. We've got other problems. We've got highways to worry about. We've got prison systems to worry about. We'll do our part, the Federal Government has to do theirs."

Dr. GRAHAM. I think all I can say is that I certainly understand your concern. Things may vary from State to State. The assumption clearly is that the States will be responsible partners, and that even if the technical nature of our sharing of participation in the health care system has changed by some transfer of medicaid authority, the belief is that the states will continue to be concerned about and involved in the level of provision of services to their populations.

I see Mr. Itteilag reaching for the microphone. I don't know whether he wishes to add something.

Mr. ITTEILAG. There is always some risk to adding to a debate like this, Senator, but with respect to medicaid, one aspect of the situation that is absolutely unclear at this point is that while the President has said the Federal Government will assume financial responsibility for medicaid, we have not yet reached any conclusions on who is going to administer medicaid. Right now, as you know, for all practical purposes the States administer medicaid for the Federal Government to the tune of about $900 million a year and several thousand State and local employees. Until one tries to grapple with that aspect of the situation, it is rather difficult to see what direction the medicaid situation is going to go.

If the Federal Government were to assume administrative responsibility for medicaid in the manner in which it has responsibility for medicare, then we are talking about a very different kind of situation than now exists. If the States continue to have the administrative responsibility, then perhaps the incentives for competition that you mentioned are something that could be built into whatever proposals are made, specifically with respect to medicaid.

HEALTH SYSTEMS AGENCIES

Senator SCHMITT. I am not sure what you said, but we will leave it on the record and I will study it later.

It has been brought to my attention that regulations mandate HSA's to employ one staff member per 100,000 people in a State. How can the Department possibly adhere to this requirement when some HSA's are at the minimum funding level now?

Dr. GRAHAM. Those are not regulations, Mr. Chairman. That is the statute.

Senator SCHMITT. Statute?

Dr. GRAHAM. It is statutory, sir.

CERTIFICATE OF NEED PROGRAMS

Senator SCHMITT. We will check on that. Thank you.

State health planning and development agencies develop State health plans, enact and implement a State certificate of need program, and establish and maintain a State health coordinating council. Do you have any data on how effective this certificate of need process has been overall in controlling unnecessary capital investments by hospitals and other health facilities? It appears to have been quite effective in New Mexico, based on my own information. How does it look nationwide?

Dr. GRAHAM. The results of a series of studies done by various interests over the last 2 to 3 years provide us with conflicting results, and, if I might at this point in the record, I will submit a 6- to 8-page summary of these studies for the committee's attention.

Senator SCHMITT. That would be very helpful.

[The information follows:]

Effectiveness of Certificate of Need (CON)

In November 1981, HRA conducted a CON Program Review that focused on an evaluation of the overall effectiveness of CON review as reflected by research and studies to date and on what lessons had been learned by the States as they established and operated their programs on a day-to-day basis. More recently, the Congressional Budget Office (CBO) completed an analysis, "Health Planning: Issues for Reauthorization," which examined, among other things, the effectiveness of CON. The findings regarding this issue are the same--there is no available evidence on a national basis that CON alone has had a demonstrable effect on aggregate hospital costs or investments.

Beginning in the mid-70's, a succession of analytical studies concerning the effectiveness of certificate of need have been published in the scientific literature. These studies have generally indicated that CON may lower capacity, or bed growth, thus limiting utilization; that it has no consistent effect on other forms of capital investment such as those for new equipment or services, however; and that, by itself, it has no effect on hospital costs. (Sloan and Steinewald, Salkever and Bice, Policy Analysis, Inc.)

Current research is addressing new and more complex questions regarding CON. One current research study is assessing the effects of combinations of regulatory programs on the diffusion of computerized tomography (CT) scanners in the United States. (Bice and Urban.) Preliminary findings suggest that a combination of stringent price regulation (i.e., rate-setting) and non-price regulation (e.g., CON) lowered the rate of diffusion of CT scanners. In the absence of stringent price regulation, there does not appear to be an independent effect of CON on that diffusion. The same study has indicated that a combination of stringent price and non-price regulation also lowered the rate of growth of average hospital per diem costs during the period 1974-1979.

A summary of these and other studies follows:

SUMMARY OF SELECTED EVALUATION AND RESEARCH STUDIES OF CERTIFICATE OF NEED

Study:	An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures, by Craig Coelen and Daniel Sullivan; Health Care Financing Review, Winter, 1981.
Findings:	Results varied widely but, in general, CON review appeared more successful in restraining growth in costs per capita than costs adjusted for admissions or patient days.
Limitations:	Individual State CON programs showing effects varied across equations, making interpretation difficult. The definition of CON review used in the study was also a drawback.

Study: Measuring Regulation and its Effects on Hospital Behavior, by Nicole Urban and Thomas W. Bice; University of Washington, September 1981 (unpublished).

Findings: States with stringent price and nonprice regulation lowered the rate of growth of average hospital per diem costs during the period 1974-1979. Also, the combination of stringent rate setting and CON lowered the rate of diffusion of CT scanners.

Study: The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital, by Paul L. Joskow: Bell Journal of Economics, Autumn, 1980.

Findings: All else being equal, hospitals with the same level of use were found to have a 6 percent lower supply of hospital beds in States with CON review, rate regulation, or both, than in other States. Also found that CON review alone reduced the supply of beds, although the extent of the reduction was not estimated.

Limitations: Small sample size and the potential sensitivity of the outcome to assumptions made in the queuing model were drawbacks.

Study: Evaluation of the Effects of Certificate of Need Programs, by Policy Analysis, Inc.; January 1981. (Sponsored by Health Resources Administration, DHHS.)

Findings: CON has not significantly reduced hospital capital growth. This held true for both mature and younger CON programs. CON was not effective in controlling the level or rate of increase in hospital costs and had no apparent impact on the distribution of facilities or the structure of the hospital industry, i.e., public/voluntary v. private hospitals.

Data and approach: The study examined the effects of CON on: (1) hospital capital investment; (2) geographic distribution of hospital beds; (3) hospital cost indicators such as per capita costs, per admission costs; (4) the structure of the hospital industry. The study also looked at interstate program variations. The data base consisted of individual hospital data items from nearly 1,400 hospitals over a nine year period (1967-1976). Regression and other statistical analyses were performed.

Limitations: Study only covered period through 1976 when few CON programs could be considered mature.

Study: Regulating Hospital Capital Investment: The Experience in Massachusetts, by Julianne R. Howell; 1980. (Sponsored by National Center for Health Services Research, DHHS.)

Findings: Patterns of hospital expenditures varied by type of hospital and as a function of the completion dates of "major bed projects" and the synchrony in the construction of such projects among similar hospitals. Over the period 1972-1976, 25 percent of all projects submitted by sample hospitals to CON were either denied or significantly modified through review. By 1976 and beyond, CON review reduced all dimensions of project scale and cost by as much as two-thirds of that originally proposed.

Data and approach: Massachusetts Rate Setting Commission data and hospital investment data for five "pre-CON" years and for five years following enactment of CON were studied for 26 randomly selected hospitals in Massachusetts. Case studies were conducted in nine sample hospitals to explore the determinants and consequences taken by the institution.

Limitations: Only Massachusetts CON was studied.

Study: Institutional Response to Regulation: Certificate of Need and Hospitals, by Donald Cohodes; Ph.D. Dissertation, Harvard University, 1980.

Findings: Positive relationships were found between hospital investment and the availability of internal funds, grandfathering provisions of CON laws; and the Economic Stabilization Program; negative relationships with occupancy rates, per capita income, physicians per capita, and extent of local insurance coverage; and no relationship with a measure of local wage rates. A further finding is that CON plays an important role in determining the way in which a hospital will invest its funds, the manner in which a hospital will seek funding, and the combination of outputs which the hospital will produce.

Data and approach: Regression analysis of State aggregated AHA asset data and data on State CON program characteristics such as age, program "strength" and "commitment."

Limitations: Cohodes found unanticipated relationships which he was unable to explain.

Study: Analysis of Health Planning Agency Activities Under CON and 1122 - July, 1976 thru December, 1978, by American Health Planning Association (AHPA), November, 1980. (Developed under contract with HRA, DHHS.)

Findings: About 3,300 projects totalling $4.9 billion reviewed per year (72% hospitals, 18% nursing homes.) 81% approval rate. 14% disapproved, 3% withdrawn, 2% reduced by modification. Approved expenditures total about $4 billion per year (75% for hospitals, 17% for nursing homes, 7% for equipment.) Approval rate inversely related to HSA population size; lowest for areas with less than 3.5 beds per 1,000 population.

Data and approach: Data collected by AHPA in two national surveys, with about 85% agency response rate, on Health Systems Agencies' (HSAs) reviews.

Limitations: Data covers only formal capital expenditures reviews by HSAs' therefore, discouragement, modification or withdrawals of (potential) applications during pre-proposal negotiations are not reflected in this analysis of CON activities.

Study: Insurance, Regulation, and Hospital Costs, by Frank A. Sloan and Bruce Steinwald; 1980.

Findings: CON was found to raise costs per admission and per patient day. CON has an anticipatory effect on bed growth and a compensatory response on labor employment; i.e., hospitals recognize when CON is coming and initiate bed construction earlier than they would have in the absence of CON.

Data and approach: An econometric analysis of hospital costs and labor and non-labor inputs using AHA data from 1969 to 1975.

Limitations: None other than the lack of better data.

Study: An Integrated Approach to Evaluating the Impact of Health Planning in New England, by Codman Research Group, Inc., 1979. (Sponsored by HRA, DHHS.)

Findings: The health planning system has not been captured by health care providers, nor has it been an effective control on health care institutional expansion. P.L. 93-641 is inefficient as a regulatory program because it rests regulatory authority in the States, which vary in their commitment to the goal of containing health facility expansion. Health resource allocation decisions under P.L. 93-641 are reached primarily through political bargaining.

There are extensive differences in Medicare reimbursements and hospital expenditures, in the distribution of hospital beds and personnel, and in the rates of use of medical and surgical services per capita among hospital areas within the New England States. These differences are related to the supply of services rather than to consumer.

Data and approach: Study combines two evaluation methodologies, case studies and epidemiologic analysis of small area expenditure and utilization data to assess the impact of health planning and regulatory programs in five selected health planning areas in New England.

Limitations: Applicability of findings limited to New England States.

Study: Wendling and Warner, 1980.

Findings: Adoption of CON was found to be positively related to decreases in average occupancy rates and to hospital concentration, but no effect of trends in hospital expenditures per patient day was detected. Results are generally consistent with the view that adoption of CON is dependent on costs and benefits to existing firms in the industry.

Data and approach: Regression analysis of State adoption, no action, or defeat of CON legislation for 1968 through 1973.

Study: American Hospital Association, 1979.

Findings: Fifty-three percent of hospitals that had discontinued capital expansion plans in 1978-79 indicated that this decision was influenced by failure to obtain, or costs of obtaining, a certificate of need.

Data and approach: Tabulations of survey responses from a representative sample of hospitals in late 1979.

Study: The Impact of Certificate of Need Controls on Hospital Investments, by David S. Salkever and Thomas W. Bice: Milbank Memorial Fund Quarterly, Spring, 1976. (Research sponsored by NCHSR, DHHS.)

Findings. Study found that CON had reduced growth in beds. However, CON did not reduce total hospital capitol investment but instead had apparently redirected investment for new beds to modernization and new services and equipment. Growth in beds had been reduced by less than 10% but assets per bed had increased by 15 to 20%.

Data and approach: Estimates of Investment Impact of CON derived from cross-section, multiple regression analyses of investment by non-federal, short-term general and other special hospitals. Employs data for 1968-72.

Limitations: Data used are for 1968-72 period, prior to the nationally mandated uniform provisions regarding CON in P.L. 93-641. Only relatively few States had fully implemented CON programs by 1972.

Study: The Effect of CON Legislation on Hospital Investment, by Hellinger; Inquiry, 1976.

Findings: Negative but statistically insignificant estimates of effects of CON and 1122 reviews on mean assets were obtained. Tentative evidence of anticipatory increases in assets was also obtained.

Data and approach: Regression analysis of State aggregate mean plant assets of short-term hospitals in 1972-1973.

(This study was updated by the authors in 1979 using the same data base and correcting for deficiences in the original analysis. Essentially the same findings and conclusions were reached.)

LIMITATION OF BEDS AND CAPITAL GROWTH INCREASE

Dr. GRAHAM. What we have found is that there are some studies which would appear to indicate that certificate of need programs in specific States or sets of States have been somewhat effective in limiting the expansion of beds and the increase of capital growth in the system.

There are also other studies done by equally reputable sets of interests which would appear to indicate that certificate of need has had little or no effect on the expansion of health care capital and has indeed added to the cost of the system overall.

What I suspect we are seeing is that these studies are looking at a process very early in its development and evolution, since certificate of need in most States at the time it was studied had been running anywhere from 2 to 4 years, and that it really would have taken much longer in terms of development of the full evolution of the certificate of need process to do a fair national study that would have been able to make a determination as to the actual cost-effectiveness.

But I do believe that the studies are good, and the fact that they come out on either side of the question merely fuels the debate.

HILL-BURTON FREE CARE PROGRAM

Senator SCHMITT. What is the Department doing about reported attempts by Hill-Burton aided nursing homes to charge off so-called medicaid shortfall, that is, the difference between what medicaid pays and the institution's usual charge, to the Hill-Burton free care obligation, thus reducing the amount of actual free care provided?

Dr. GRAHAM. At the present time, Mr. Chairman, that is inconsistent with the regulations under which we are operating a free care provision.

If I could, I would like to have Dr. Fiori just speak briefly as to what information we have as to the prevalence of that practice.

Dr. FIORI. I don't know that we can provide any detailed information on the prevalence of the practice. What I do know is that the nursing homes themselves have raised the question about the existing regulation, which, as Dr. Graham says, does not allow the writeoff, and that is because, for the most part, many of their beds are filled by medicaid patients. They have little opportunity to bring patients into the facility because their occupancy rates are very high and, therefore, they are finding it more difficult in acute care institutions to meet their obligations.

They have raised the issue, but at the moment they are not permitted to do that kind of a writeoff.

TASK FORCE STUDY ON HEALTH PLANNING AND HILL-BURTON

Dr. GRAHAM. I might add, Mr. Chairman, at the present time the Department does have a task force studying the regulations, not only for the health planning program, but the free care assurances, Hill-Burton program, and it is possible that some time early or late this spring that we will be considering publishing new NPRM's that may make some changes in the regulations that are presently in effect.

These have not been reviewed by the Secretary though. So it would be premature for me to comment.

Senator SCHMITT. You expect the task force to have some report completed by when?

Dr. GRAHAM. My sense right now, depending upon the Secretary's schedule and the issues that the task force raises that he may be concerned with, is that we are on a time line when decisions can be made by him by early to mid-spring. I would anticipate late April or early May. But again, until he has the opportunity to look at the materials and see what the recommendations and the reasoning of the task force are, I can't anticipate when we might move because he may have some problems with those.

FINANCIAL DISTRESS GRANTS

Senator SCHMITT. Financial distress grants have been available to health professions schools in serious financial distress to assist in meeting their costs of operation. For how long do you expect health professions schools in financial distress to require advanced financial distress assistance?

Dr. GRAHAM. Under the provisions of the Reconciliation Act last year, we now have a new authorization of advanced financial distress for which only the four schools that are presently receiving financial distress, which are Meharry Medical and Dental, Xavier, and Tuskegee, are eligible.

The provision of advanced financial distress in the Reconciliation Act is that those schools must prepare a 5-year plan which shows at the end of that 5-year period that they will no longer be dependent upon special Federal revenues to keep them afloat. That plan must then be reviewed by an outside panel of three individuals, and they must make a finding that the plan is feasible before the Secretary may allocate the funds presently appropriated in fiscal 1982.

All four of those schools have submitted those plans; they have been reviewed by the Panel on Advanced Financial Distress; and we are just in the process of implementing their recommendations.

The implication is, since the panel's recommendations were that one school have its plan approved—Tuskegee—and that the three others have their plans approved with contingency—in other words, so long as they meet these contingencies, the panel felt that their plans were feasible. These institutions will have the opportunity to enter into a 5-year cooperative agreement with the Department, consistent with the plan that they submitted that will have them independent of further financial distress funding at the end of that 5-year period.

So I believe, consistent with the Congress change of this authority in the last Reconciliation Act, that we are now looking at a maximum 5-year horizon of continued financial distress funding for these schools.

If the schools continue to meet the plan and meet the benchmarks that they have set out themselves, I would anticipate, given appropriation availability, that we will continue to fund them for 5 years. If they find themselves not able to meet those benchmarks, then consistent with the provisions in the Reconciliation Act and the advice of that panel, I would anticipate cessation of Federal funding for one or more of those schools short of 5 years.

MEHARRY MEDICAL AND DENTAL SCHOOLS

Senator SCHMITT. Is Meharry included?

Dr. GRAHAM. Yes, sir. Both Meharry Medical School and Dental School are included and have been, on the recommendation of that panel, approved with contingencies.

Senator SCHMITT. What do you mean, with contingencies?

Dr. GRAHAM. The panel, in looking at their 5-year plan, felt that it was feasible so long as certain major benchmarks were met. For instance, one of the contingencies is that they continue to receive outside philanthropic or private support in the accelerating fashion that they had projected in their 5-year plan; and that if they continue to do that, then their plan in that instance looks feasible. But if that support does not develop, then the panel would have very serious questions as to the feasibility of their eventual 5-year workout plan.

Senator SCHMITT. If they don't make their target in philanthropic contributions, does that mean then that something else will happen?

Dr. GRAHAM. Something else in what sense, sir?

Senator SCHMITT. Well, the Federal Government either will require that they merge with some other institution or that they begin to close their doors or what?

Dr. GRAHAM. Well, I believe under the provisions of advanced financial distress, as the Congress passed it last year, the additional Federal options for action are very limited, and my anticipation would be that if one or more of these schools could not, or finds that it does not, meet the contingencies or other elements of the plan that they themselves have presented us, then the proposal which must be made to the Secretary at that time, under the provisions of the act, is a cessation of Federal financial distress funding.

I believe that in the case of most of those schools cessation of such funding would likely raise the issue of closing the school.

HEALTH PROFESSIONS SCHOOLS MERGERS

Senator SCHMITT. Are there potential mergers of these schools with nearby institutions that are reasonably sound?

Dr. GRAHAM. I'm just reviewing quickly the types of schools and where they are located. Meharry, of course, is in Nashville. It has medical and dental facilities. And there is the private medical school, Vanderbilt, also in Nashville. Their histories are so dissimilar I would find the prospect of merger to be unlikely, although not impossible.

Tuskegee is a veterinary school. Auburn would have the closest veterinary school, some 20 miles distant. So, in terms of geography, that might be a possibility.

Xavier is a pharmacy school in New Orleans. There is one other pharmacy school in New Orleans.

I think, though, as I have met with representatives of these schools, and again understanding the very different histories that the schools have and the very major contribution that they have made to the black community as an opportunity for education and for professional growth, that a merger with a school that did not have that history and that historical commitment to those goals would be a very unlikely outcome.

Senator SCHMITT. Instead you would force them to close?

Dr. GRAHAM. Well, I don't know where the term "force" comes from, sir.

FINANCIAL DISTRESS ASSISTANCE

Senator SCHMITT. Well, if the law sets certain guidelines for the continuation of distress assistance, what's the option? It seems to me that merger is the middle ground in which reasonable people could find ways of preserving the traditions, if in fact they are unable to continue on their own.

Dr. GRAHAM. I have the feeling that you are asking me a question of congressional intent. My sense from listening to the discussions about financial distress in the Congress over the last 3 to 4 years and my understanding of some of the discussions which went into the decision to develop the new advanced financial distress authority is that the Congress itself was seeking some degree of finite commitment on the part of an appropriation to these schools, and I can only assume that it is implicit in the Congress mind that, at the outer boundary of that finite commitment, the Federal sector has done what it can do and that at least the financial resource, if it is provided, would be terminated.

Senator SCHMITT. I am not arguing with that. What I am suggesting is that if it appears that the contingencies or the milestones in the plans cannot be met, the Federal Government would use its "good offices" to assist in finding an alternative that would be consistent with congressional intent but would also be consistent with preserving the unique character of these schools even though they may be merged administratively and financially with a larger institution, one more sound financially.

Dr. GRAHAM. Let me first make the offer to submit in the record at this point, the contingencies for each of these schools, as they are a matter of public record; second, to say that should we come to that point where it appears that the contingencies cannot be met, and the milestones cannot be met, I suspect, from the little bit I know about the politics of health professions education, that the potential for merger could be far more forcefully articulated by the Congress than by the Secretary of HHS.

Senator SCHMITT. Submit the information for the record.

[The information follows:]

Xavier University
College of Pharmacy

CONDITIONS OF AWARD

Failure to meet the specific conditions listed below may be grounds for the Secretary or Designee to terminate further funding under this program:

1. For the purposes of this agreement, the binding document of reference is the application for Advanced Financial Distress, submitted by the College on January 12, 1982 (hereafter referred as the "plan"), including its several attachments, appendices, and supplementary submissions.

2. Implement by June 1, 1982, and annually thereafter, the following proposed schedule of tuition and fees as specified in the 5-year plan:

YEAR	1982-83	1983-84	1984-85	1985-86
RATE	$3,400	$3,800	$4,200	$4,600

3. Provide written confirmation by June 1, 1983, that the United Negro College Fund and the College have consummated the UNCF matching grant of $450,000.

4. Document by September 30, 1982, and annually thereafter, that the Institution has achieved or exceeded the revenues projected for receiving income from fund-raising activities (pharmaceutical, cosmetic corporate enterprises and other institutions listed in application) as specified in the 5-year plan:

In Thousands

YEAR	1981/82	1982/83	1983/84	1984/85	1985/86
INCOME	$75	$100	$120	$150	$200

5. Produce evidence at the conclusion of the next legislative session of a binding commitment from the State of Louisiana which demonstrates increased support for the College of Pharmacy and the effect on the projected annual deficits. Submit, within two months of acceptance of this award, a plan of action, with timetable, for achieving this condition.

6. Select and/or appoint a Dean of Pharmacy by September 1, 1982, with the Dean's reiteration and reaffirmation of the 5-year plan within 90 days of appointment.

7. Submit a report by September 30, 1982 and annually thereafter, which demonstrates progress in achieving increased sponsored program support as proposed in the 5-year plan.

8. One hundred thirty-nine thousand, five hundred thirty-six dollars ($139,536) in the 01 year is restricted for the purpose of retiring a portion of the $350,000 debt owed by the College to the University. By June 30, 1982, the Institution shall present to the Administrator, HRA, a plan to amortize the remaining $210,461 debt.

9. Submit by September 30, 1982, and each September 30 thereafter, a progress report on the implementation of recommendations arising out of the most recent accreditation review by the American Council on Pharmaceutical Education. Include a copy of the most recent accreditation report on the College of Pharmacy.

10. Provide by September 30, 1982, and annually thereafter, a report with the annual request for continued funding. As a minimum, the progress report shall relate financial, management, administrative activities and accomplishments to the goals specified and projected in the approved plan. The request should also include that Xavier University reaffirms its commitment to continue the College of Pharmacy even though the 5-year plan projects a deficit in year five because Xavier can the deficit in its overall operation.

11. Report immediately to the Administator, HRA, any significant accomplishments that would accelerate completion of the 5-year plan or any significant difficulties that would adversely affect the Institution's ability to achieve annual plan projections, or to complete the 5-year plan.

12. If in any academic year there is a deficiency of greater than 15% of anticipated revenues (exclusive of financial distress) or an excess of greater than 15% of projected expenses (including deficiencies and excesses carried forward) the Secretary or Designee shall have cause to review this agreement, with question as to the feasibility of the plan.

13. There shall be no changes in the plan submitted by the College in its entirety, or in these conditions, without the prior written agreement of both the Institution and the Department of HHS.

TUSKEGEE INSTITUTE
School of Veterinary Medicine

CONDITIONS OF AWARD

Failure to meet the specific conditions listed below may be grounds for Secretary or Designee to terminate further funding under this program:

1. For the purpose of this agreement, the binding document of reference is the application for Advanced Financial Distress, submitted by the College on January 15, 1982 (hereafter referred as the "plan"), including its several attachments, appendices, and supplementary submissions.

2. Implement by June 1, 1982, and annually thereafter, the following proposed schedule of tuition and fees as specified in the 5-year plan:

YEAR	1981/82	1982/83	1983/84	1984/85	1985/86
RATE	$3,000	$3,250	$3,500	$3,750	$4,000

3. By October 30, 1982, advise the Administrator, HRA, what anticipated effects the assessment reports, now in formulation

by the President, will have on the overall timetable of the 5-year plan for the school of veterinary medicine.

4. Document by September 30, 1983, and annually thereafter, that the Institution has achieved or exceeded the revenues projected for receiving income from the fund-raising campaign as specified in the 5-year plan:

In Thousands

YEAR	1982/83	1983/84	1984/85	1985/86
INCOME	$35	$200	$325	$425

5. Provide by September 30, 1982 and annually thereafter, a progress report with the annual request for continued funding. As a minimum, the progress report shall relate financial, management, administrative activities and accomplishments to the goals specificied and projected in the approved plan. The report for Tuskgee School of Veterinary medicine should specifically address:

   a. the status of the contractual arrangements with foreign governments and States in terms of increases and/or decreases in the flow of revenue.

   b. the progress in developing clinical services and the resulting revenue imporvement, as specified in the 5-year plan:

YEAR	1981/82	1982/83	1983/84	1984/85	1985/86
CLINICAL INCOME	$140,000	$150,000	$165,000	$181,500	$199,600

   c. the progress in filling faculty vacancies

   d. the issue of support from the State of Alabama and what effect it will have on the anticipated progress toward success of the 5-year plan.

6. Annual requests for continued funding should indicate that Tuskegee Institute: (a) reaffirms its commitment to continue the School of Veterinary Medicine even though the 5-year plan projects a deficit in year five because Tuskegee can absorb the deficit in its overall operation and (b) whether or not the Institute is able to absorb part and/or all of the school's operating deficit for the particular year of funding or (c) reduce the number of years in which it must be funded via the Advanced Financial Distress Award Program.

7. Report immediately to the Adminstrator, HRA, any significant accomplishments that would accelerate completion of the 5-year plan or any significant difficulties that would adversely affect the Institution's ability to achieve annual plan projections, or to complete the 5-year plan.

8. If in any academic year there is a deficiency of greater than 15% of anticipated revenues (exclusive of financial distress) or an excess of greater than 15% of projected expenses (including deficiencies and excesses carried forward) the Secretary or Designee shall have cause to review this agreement, with question as to the feasibility of the plan.

9. There shall be no changes in the plan submitted by the School, in its entirety, or in these conditions, without the prior written agreement of both the Institution and the Department of HHS.

Meharry Medical Colleges
School of Medicine

CONDITIONS OF AWARD

Failure to meet the specific conditions listed below may be grounds for the Secretary or Designee to terminate further funding under this program:

1. For the purpose of this agreement, the binding document of reference is the application for Advanced Financial Distress, submitted by the College on January 15, 1982 (hereafter referred to as the "plan"), including its several attachments, appendices, and supplementary submissions.

2. Implement by June 1, 1982, and annually thereafter, the following proposed schedule of tuition and fees as specified in the 5-year plan:

YEAR	1981/82	1982/83	1983/84	1984/85	1985/86
RATE	$6,500	$7,500	$8,500	$9,500	$10,500

3. Submit by April 1, 1982, a copy of the newly implemented practice plan. By September 30, 1982 and annually thereafter, verify that the practice plan has provided income to the School of Medicine in accordance with the 5-year plan as follows:

YEAR	1981/82	1982/83	1983/84	1984/85	1985/86
INCOME	$59,000	$75,000	$83,000	$91,000	$100,000

4. Produce evidence at the conclusion of the next legislative session of a binding commitment from the State of Tennessee which demonstrates increased support for the School of Medicine and the effect on the projected annual deficits.

5. Produce documentary evidence at the end of each contract year that agreements with Southern Regional Education Board contract States remain in effect, and that annual revenues have been generated as specified in the plan.

6. Document by September 30, 1982, and annually thereafter, that the Institution has achieved or exceeded the revenues proejcted for income from the private fund-raising campaign as specified in the 5-year plan:

YEAR	1981/82	1982/83	1983/84	1984/84	1985/86
GIFTS	$1,091	$1,091	$1,135	$1,180	$1,227
OTHER		780	814	850	898
TOTAL	$1,091	$1,871	$1,949	$2,030	$2,125

7. Provide a plan by September 30, 1982, to accomplish a phase-in of Meharry Medical School affiliation with Nashville General Hospital, with such affiliation to provide for increased clinical training opportunities for Meharry students and residents, and reimbursement for Meharry faculty costs. The plan must be implemented by September 30, 1983.

8. Provide by September 30, 1982, and each September 30 thereafter, a schedule of anticipated academic appointments in

the next academic year, with specification of how such schedule of appointments will address the provisions in the College's plan for meeting accreditation standards, enriching student education, and increasing sponsored research.

9. Awarded funds may not be used for Hubbard Hospital's operations or debt service (either outstanding mortgage or accruing debt to DHHS).

10. Submit by September 30, 1982, a progress report on the implementation of the recommendations in the management letter dated November 20, 1981 from Peat Marwick & Mitchell & Company on fiscal reform.

11. Submit by September 30, 1982, and each September 30 thereafter, a progress report on the implmentation of recommendations arising out of the most recent accreditation review by the ACME. Include a copy of the most recent ACME report on the School of Medicine.

12. Select and/or appoint a Dean of Medicine by September 1, 1982, with the Dean's reiteration and reaffirmation of the School's 5-yearr plan within 90 days of appointment.

13. Provide by September 30 a progress report with the annual request for continued funding. As a minimum, the progress report shall relate financial, management, and administrative activities and accomplishments to the goals specified and projected in the approved plan.

14. Report immediately the Administrator, HRA, any significant accomplishments that would accelerate completion of the 5-year plan or any signifieant difficulties that would adversely affect the Institution's ability to achieve annual plan projections, or to complete the 5-year plan.

15. The funds awarded are subject to all conditions of the executed management, repayment, and other fiscal agreements between Meharry Medical College, Inc. and the Department of Health and Human Services (DHHS), formerly DHEW. This 01 year award includes $720,000 which may not be obligated by the School of Medicine pending amendment of the Repayment Agreement signed March 20, 1980.

16. Abideby the Management Agreement between Meharry Medical College and the Department as in effect on the date of this award, and as amended at any time during the project period.

17. Abideby the Repayment Agreement between Meharry Medical College and the Department as in effect on the date of this award, and as amended at any time during the project period.

18. If in any academic year there is a deficiency of grater than 15% of anticipated revenues (exclusive of financial distress) or an excess of greater than 15% of projected expenses (including deficiencies and excesses carried forward) the Secretary or Designee shall have cause to review this agreement, with question as to the feasibility of the plan.

19. There shall be no changes in the plan submitted by the College, in its entirety, or in these conditions, without the prior written agreement of both the College and the Department of HHS.

Meharry Medical Colleges
School of Dentistry

CONDITIONS OF AWARD

Failure to meet the specific conditions listed below may be grounds for the Secretary or Designee to terminate further funding under this program:

1. For the purposes of this agreement, the binding document of reference is the application for Advanced Financial Distress, submitted by the College on January 15, 1982 (hereafter referred to as the "plan"), including its several attachments, appendices, and supplementary submissions.

2. Implement by June 1, 1982, and annually thereafter, the following proposed schedule of tuition and fees as specified in the 5-year plan:

YEAR	1981-82	1982-83	1983-84	1984-85	1985-86
RATE	$6,500	$7,500	$8,500	$9,500	$10,500

3. Submit by April 1, 1982, a copy of the newly implemented practice plan. By September 30, 1982 and annually thereafter, verify that the practice plan has provided income to the School of Dentistry in accordance with the 5-year plan as follows:

YEAR	1981-82	1982-83	1983-84	1984-85	1985-86
INCOME	$37,000	$114,000	$202,000	$222,000	$244,000

4. Produce evidence at the conclusion of the next legislative session of a binding commitment from the State of Tennessee which demonstrates increased support for the School of Dentistry and the effect on the projected annual deficits.

5. Produce documentary evidence at the end of each contract year that agreements with Southern Regional Education Board contract States remain in effect, and that annnual revenues have been generated as specified in the plan.

6. Document by September 30, 1982, and annually thereafter, that the Institution has achieved or exceeded the revenues projected for income from the private fund-raising campaign as specified in the 5-year plan:

YEAR	1981-82	1982-83	1983-84	1984-85	1985-86
GIFTS	$342	$244	$255	$266	$281

7. Provide by September 30, 1982, and each September 30 thereafter, a schedule of anticipated academic appointments in the next academic year, with specification of how such schedule of appointments will address the provisions in the College's plan for meeting accreditation standards, enriching student education, and increasing sponsored research.

8. Awarded funds may not be used for Hubbard Hospital's operations or debt service (either outstanding mortgage or accruing debt to DHHS).

9. Submit by September 30, 1982, a progress report on the implementation of the recommendations in the management letter dated November 20, 1981 from Peat Marwick & Mitchell & Company on fiscal reform.

10. Submit by September 30, 1982, and each September 30 thereafter, a progress report on the implementation of recommendations arising out of the most recent accreditation review by the Commission on Dental Accreditation. Include a copy of the most recent accreditation report on the School of Dentistry.

11. Select and/or appoint a Dean of Dentistry by September 1, 1982, with the Dean's reiteration and reaffirmation of the School's 5-year plan within 90 days of appointment.

12. Provide by September 30 a progress report with the annual request for continued funding. As a minimum, the progress report shall relate financial, management, and administrative activities and accomplishments to the goals specified and projected in the approved plan.

13. Report immediately to the Administrator, HRA, any significant accomplishments that would accelerate completion of the 5-year plan or any significant difficulties that would adversely affect the Institution's ability to achieve annual plan projections, or to complete the 5-year plan.

14. The funds awarded are subject to all conditions of the executed management, repayment, and other fiscal agreements between Meharry Medical College, Inc. and the Department of Health and Human Services (DHHS), formerly DHEW. This 01 year award includes $280,000 which may not be obligated by the School of Medicine pending amendment of the Repayment Agreement signed March 20, 1980.

15. Abide by the Management Agreement between Meharry Medical College and the Department as in effect on the date of this award, and as amended at any time during the project period.

16. Abide by the Repayment Agreement between Meharry Medical College and the Department as in effect on the date of this award, and as amended at any time during the project period.

17. If in any academic year there is a deficiency of greater that 15% of anticipated revenues (exclusive of financial distress) or an excess of greater than 15% of projected expenses (including deficiencies and excesses carried forward) the Secretary or Designee shall have cause to review this agreement, with question as to the feasibility of the plan.

18. There shall be no changes in the plan submitted by the College, in its entirety, or in these conditions, without the prior written agreement of both the College and the Department of HHS.

SPECIAL PROJECT GRANT AUTHORITY

Senator SCHMITT. The Reconciliation Act extended the authority for capitation grant assistance to schools of public health without extending this authority for other health professions schools. Since no funds are requested for capitation assistance for fiscal 1983, how would you anticipate that public health schools will be able to make up for the loss of funds?

Dr. GRAHAM. What we are proposing in place of capitation, and, indeed, it is in place of the institutional support provisions for both the schools of public health and health administration, is a special project grant authority that would cover schools of public health and health administration.

Our feeling is that, within the very limited resources that we have available for health professions education, the opportunity to provide those resources in a targeted fashion in areas of highest priority is a more responsible one for us than general institutional support.

I believe the legislative provisions that would accomplish that change are presently under review at OMB but have not yet been submitted to the Congress.

Is that correct, Mr. Itteilag?

Mr. ITTEILAG. That is correct, Senator.

Senator SCHMITT. But you would agree that some public health schools will be significantly impacted by a lack of funds that they had become dependent upon?

Dr. GRAHAM. Well, the use of the term "significant" is the only one that gives me pause. Certainly we recognize that our proposal would make funds available to the schools of public health via a different mechanism, and it would be a competitive mechanism rather than a formula mechanism. There are some schools which might continue to get the same amount of Federal dollars, or conceivably even more, and some schools would get none.

Certainly when you change an allocation of Federal support, and one year you have Federal money and the next year you don't, there is impact. Whether or not it is significant, I suspect is in the mind of the beholder.

Senator SCHMITT. The budget includes a request for the special projects grants?

Dr. GRAHAM. Yes, sir, it does.

Senator SCHMITT. How much is that?

Dr. GRAHAM. The exact figure I believe is $2.5 million, and that is combined authority for schools of public health and health administration.

Senator SCHMITT. What is the status of the proposal to repeal graduate programs in health administration and health administration traineeships and to reestablish the authority for the special projects program? Is that in the legislation that you are referring to?

Dr. GRAHAM. Yes, sir. That is the legislative change presently being reviewed by OMB.

Senator SCHMITT. What do you do if these proposals are not agreed to by the Congress?

Dr. GRAHAM. Well, I think under that circumstance we would have to accept whatever allocation of resources the Congress makes under the existing authority.

Senator SCHMITT. The old throw-up-your-hands approach, right?

Dr. GRAHAM. Well, we have not made any request for funds in the existing lines in the budget, sir.

FAMILY MEDICINE RESIDENCIES AND TRAINING PROGRAMS

Senator SCHMITT. Family medicine residencies and training programs provide grants and contracts to hospitals and medical schools toward the goal of reducing the downward trend in the number of general practitioners which has been occurring in recent years. Why has the administration proposed to reduce funding for this program by some $7 million from what was provided in fiscal 1982?

Dr. GRAHAM. Actually, sir, I believe that our proposal for family medicine residencies and family medicine departments is only about $2 million different from what was provided in the continuing resolution in 1982. The continuing resolution amount is roughly $25 million for the residencies and $7.6 million for the departments. Our request in 1983 is $22.5 million for residencies and roughly $7 million for departments.

This continues to be an area of very high priority for us and one which we are quite supportive of.

Senator SCHMITT. We are going to have to check our numbers out. They come out a little bit differently from yours.

Would you agree that the major reduction is in general internal medicine and pediatrics?

Dr. GRAHAM. For this year the major portion of the reduction is in that area, yes, sir.

Senator SCHMITT. Do you feel that the administration's proposals are supportive of the general need for general practitioners that has developed in recent years?

Dr. GRAHAM. Again, I must respond in the context of the budget constraints which we do face, recognizing that the health professions area is an area where we have seen substantial reductions over the past 2 years. The fact that the primary care area—family medicine, general internal medicine, and pediatrics—has been able to roughly hold its own is something which I believe reflects our priority.

AREA HEALTH EDUCATION CENTERS

Senator SCHMITT. Of course, the concern of the subcommittee is that in dealing with the present budgetary contingencies or exigencies we may be sowing the seeds for even greater problems in the future. As you may or may not have noted, the subcommittee and the full Appropriations Committee have been very, very concerned about the progress of developing preventive medicine and low-cost medical care options in order to keep people out of the more expensive hospital treatment situations, and it is not clear—and we will continue to examine this—that the administration's priorities in these things are consistent with that longer term aim of reducing the demand on the expensive treatment opportunities that exist within the hospital community. General practitioners can play a very important role in that area, as can the general primary care, rural primary care activity.

The area health education center programs link the resources and training programs of health science centers to community hospitals and other local educational institutions to provide training which specifically addresses the health personnel needs of particular communities. Has the AHEC program been so successful in providing accessibility and availability of primary medical personnel to needy areas that we now can reduce their budget by, I think, $4.3 million?

Dr. GRAHAM. I think our assessment of the AHEC program, both what you might call the first flight of projects, which started in the early 1970's, and the second flight, which started in 1979 and 1980, is that it has, in general, been a very successful program and we are very happy with the way that it has developed; and that the individual projects, particulary those in the first set of grantees, have, by and large, been able to maintain their activities even after the cessation of Federal funds.

What our budget reflects in fiscal 1983, again with the general constraints, will allow for the continued orderly development of the ongoing eight AHEC projects which are presently in various stages of development. There is this 5- to 6-year developmental pattern; there is a peak year in terms of funding; and then an attenuation of funding.

Some of the programs in that second flight are already into the periods of their development where they seek and receive less Federal funding each year than the prior year. So that, in part, is a contribution to that diminution in funds.

AHEC COMPETITIVE CYCLE

Senator SCHMITT. How did you determine which AHEC's would drop out of the program and which would continue?

Dr. GRAHAM. What we have done thus far is to have a competitive cycle. Let me speak now just to the ones that are presently active. We had a competitive cycle where we, in about 1979, opened up to any interested applicant the opportunity to participate in the AHEC program. There were 10 successful applicants. They all received the first year's funding. In the next 2 fiscal years, two of those originally successful applicants dropped out, largely because they determined that they could not, or chose not to, meet the full set of requirements for participation in the program.

As you are aware, there is a fair amount that is demanded of the medical school or the osteopathic school and of the local communities as participants, particularly in the area of cost sharing and a full range of curriculums opportunities. Two of those projects just decided, once they got into it, that they would rather go their own way in a little bit different model than the Federal model. Of the other eight, it is our intention right now to continue the funding of all of those eight through the full cycle. It would only be that if resources became even more constricted than are presently proposed, that we would have to step back and run a competitive cycle within those eight.

So, for the eight that were remainders of the second cycle originally started in 1979, we anticipate appropriations being available, full funding for the full course of their development.

Senator SCHMITT. Have you looked at the rationale of those that dropped out to see if they might not be telling you something useful?

Dr. GRAHAM. We have had extensive discussions, as you might anticipate, with those institutions as they reached the decisions to drop out, and I would have to say that in both cases that I am aware of, the parting of the ways was amiable. The basic disagreement that we came to is how thorough and far-ranging an institutional commitment must be made by the grantee to recieve the funds, and I would have to say that I think we are appropriately hardnosed about it.

My view of the AHEC program in terms of Federal support is that we are attempting to get primary care providers in areas of the country and areas of the State where they aren't right now; and that requires, in many cases, a different type of student, a different type of attitude, and a different type of training. That requires markedly different institutional behavior.

Some of those institutions, I think, as they got into the program, found that they just didn't want to make all of those behavioral changes. I think they got into the program in good faith and out of it in good faith, but I am not sure that the message that we heard from them would change my mind about the way to administer the AHEC program. I think one of the reasons it has been relatively successful is that the institutions that have received the funding have indeed made profound changes in their educational curriculum for those participants, and I think that is what we have to require.

NURSING PROGRAMS

Senator SCHMITT. Institutional assistance for nursing programs consists of the advanced nurse training program, the nurse practitioner program and special projects program. During our hearings last year in discussing the question of distribution of nurses and retention of trained nurses in their profession the Secretary indicated that a task force was meeting to study this matter. What are the results of the study?

Dr. GRAHAM. We presently have under contract with the Institute of Medicine a major 2-year study that is addressed primarily to the problems of nursing supply in the United States, but also to other issues related to nursing—education, distribution, and job performance.

I am unaware of the specifics of the Secretary's prior testimony. I must assume that he was probably referring to that study, which is halfway completed. The products thus far are encouraging, but we are not in a position right now to say anything definitive about what the essential problems are or why, in the face of markedly increased numbers of nursing graduates over the last 10 years, there is still a protracted problem in many areas of the country of a lack of nurses at the bedside.

Senator SCHMITT. And a year of study hasn't given you any new ideas? Secretary Schweiker indicated that within 2 or 3 weeks of the testimony that he gave in April of last year that this study would be a major activity.

Dr. GRAHAM. If I might check with Mr. Hatch, I do not recognize the task force or study that he might have been referring to.

Senator SCHMITT. Let me quote him: "I have a group headed by the Assistant Secretary for Planning and Evaluation that is working on it." This is the task force on nursing. "I must say candidly though that it will be another 2 to 3 weeks before we can devote 100 percent of our time to it."

Dr. GRAHAM. If you say he said it, he said it, but I do not know what the task force is, and I have checked with the person in the room that knows most about nursing and he doesn't recognize the task force. Let me simply say that I will pursue the Secretary's comment to you and for the record provide a response to your question.

[The information follows:]

The task force referred to by the Secretary in last year's Senate hearings is the competition task force headed by the Assistant Secretary for Planning and Evaluation. No departmental task force has been created to study specifically the issues of nursing distribution and retention.

Dr. GRAHAM. In terms of what we are doing as a department and as an agency right now to gain better understanding of the dynamics of nursing employment and supply, the major activity that we have ongoing, besides the in-house activities that we carry on day in and day out, is this cooperative work with the Institute of Medicine, and I think the Institute feels very strongly that the 2-year time period that they have set out for completion of that study is at best a very tight one, and the fact that we are a year into it and do not have an answer to a problem that has been with us some 20 or 30 years, is not surprising.

BUDGET REQUEST FOR NURSING

Senator SCHMITT. So the basic thing is, you don't think money is the answer, so you are cutting out almost $30 million in 1982 and another $15 million relative to 1981?

Dr. GRAHAM. I think as it relates specifically to the budget request, there is a strong feeling, and it is a feeling which I share, that simple expansion of the nursing supply does not appear to be the answer to nursing shortages in bedside care in hospitals.

Senator SCHMITT. Well, aren't you going to aggravate the problem? Even though you don't understand it, aren't you going to aggravate it if you reduce that supply since you don't know the problem?

Dr. GRAHAM. If we acknowledge that we don't understand the problem, it is hard to say that doing one thing versus another will aggravate it.

Senator SCHMITT. But you obviously have a leaky pipe. You are putting stuff in at one end and a lot is leaking out before it gets to the other end. If you reduce the supply at the beginning that means that even less is going to come out the other end even though you haven't repaired the leaks.

Dr. GRAHAM. I am not sure the pipe is leaky. The ground appears to be very absorbent. In all seriousness, the attrition from nursing education programs does not appear to be a major problem. We have had, over the last 10 years, a marked expansion in the number of nursing graduates in all types of programs—baccalaureate, diploma, and associate degree. The numbers of nurses coming out of the pipeline has gone up appreciably. The numbers of nurses involved in hospital bedside care has gone up appreciably. Even in the last 2 years we are seeing 15- and 20-percent increases. The pipeline appears to be performing very well.

In the face of that, we continue to have shortages of nurses. In the face of that, it is difficult for me to reach the diagnosis that the problem is an inadequate supply; that if we just could double it again, as we have come close to over the last 10 years, all the problems would go away.

Senator SCHMITT. If you cut it in half, does that mean you are going to have any more nurses?

Dr. GRAHAM. That would be reaching a conclusion that the budget proposed to you would have a direct effect on decreasing the capacity of nursing schools to educate nurses. I am not sure that that is a fair conclusion.

Senator SCHMITT. Of course, we are not sure that your conclusion is fair either. We don't think you know.

Dr. GRAHAM. I am willing to acknowledge that I don't have the answer to the problem, yes, sir.

Mr. ITTEILAG. I think, Senator, the continued provision of general assistance to those attending college, like the guaranteed student loan program, is far, far more important than the relatively small amount of funds that we could bring to bear on this situation.

Senator SCHMITT. Well, it's small now because you've decreased it; it was quite a bit larger 3 or 4 years ago.

When do you think you will have some kind of study on why the ground is so absorbent?

Dr. GRAHAM. Now that we are talking on the same wavelength, we do anticipate the completion of the Institute of Medicine study in another year.

Senator SCHMITT. Well, you are leaving us without any basis other than our own intuition to deal with this budget, and we were really anticipating that this year's hearings would give us more information based on the Secretary's testimony last year, and you don't have any more except you are saying you are going to cut the budget.

Dr. GRAHAM. I do apologize for not being able to explain the statement from the hearings last year. I was unaware of them and I have no explanation.

NURSING UTILIZATION

Senator SCHMITT. Is the ground saturated? Are there too many nurses out there for any more to be utilized?

Dr. GRAHAM. I have no more reason to say that than I have reason to say that the problem is there are not enough graduates. I think what we are starting to find—and we are not the only ones examining this problem—if one reads some of the literature and some of the studies being done by the National League for Nursing—is that some of the issues that they are starting to raise are not numbers issues; they are issues of working conditions; they are issues of pay; they are issues of work responsibility; and they are issues of interprofessional relations. Now, I think, in fairness, if it turns out that the answers to the problems are those, then none of the budget lines that we are discussing here today really have much to do with how nurses and doctors get along, or how much nurses get paid, or whether or not the opportunities for young nursing graduates—who are still predominantly women in today's job market—are as attracted to nursing as they are to doing anything else.

NURSING POSITIONS

Senator SCHMITT. Do you know what the number of total available positions for nurses is in the hospital economy?

Dr. GRAHAM. Total positions or total unfilled?

Senator SCHMITT. Total positions that are available and what is the total unfilled.

Dr. GRAHAM. That is a knowable figure.

Senator SCHMITT. Would you supply that for the record?

Dr. GRAHAM. Happy to do it.

Senator SCHMITT. And give us the trends of the last few years?

Dr. GRAHAM. Happy to do that, sir.

[The information follows:]

The number of registered nurses employed in hospitals has increased significantly in recent years. On a full-time equivalent basis, the number increased from 446,387 in 1973 to 693,382 in 1980, a 55-percent increase in 7 years, according to data collected by the American Hospital Association. When considered in terms of the actual number of people involved on a full- or part-time basis, the full-time equivalent count of 693,382 in 1980 reflects a total of 805,794 registered nurses employed by hospitals in that year. While data on the number of registered nurses employed in hospitals have been collected annually by AHA for a number of years, the only recent data on budgeted positions—those that are vacant and for which hospitals are actively seeking employees—were obtained by AHA in its just released 1980 study, part of a joint AHA/HRA effort to provide hard data on this major issue. That study showed an overall nationwide vacancy rate of 8.9 percent, based on 67,449 vacant R.N. positions.

It is important to note, however, that vacancies can be the result of many factors. Turnover of personnel, from one employer to another, can lead to vacancies, which, if there is not a pool of readily available applicants from which to draw, might be difficult to fill. Also, the 8.9 percent is an aggregate for the whole country and for all types of hospitals. The availability of nurses, in terms of numbers and skill levels, is clearly not uniform throughout the country. Furthermore, there may always be vacancies in the less desirable shifts, facilities, and settings.

MOVEMENT OF NURSES

Senator SCHMITT. And also, if there is any quantitative measure of the movement of nurses back into nursing. I know there are some efforts to develop alternative work schedules that have apparently been attractive in bringing nurses back into the work force because of more flexible hours, hours that they can adjust to, such as working basically four shifts in a 2-day weekend for a full week's pay and things like that. Those are very intriguing. Would you give us any quantitative information on whether they actually have a total, net effect nationally?

Dr. GRAHAM. We do have that information and will be happy to supply it.

[The information follows:]

Data from the HRA 1980 Sample Survey of Registered Nurses shows that the nurse employment rate is at the highest level it has been in 30 years. Preliminary results from that study indicate that there were an estimated 1.6 million registered nurses with licenses to practice in November 1980, of whom 1.2 million, or 76 percent, were employed in nursing. In the earlier sample study conducted by the agency in 1977, an estimated 70 percent of those with licenses were employed in nursing. Furthermore, the 1980 data suggest that the increases in the percentage of those employed in nursing occurred for all age groups, but most particularly for nurses in their 30's and 40's, the ages at which family responsibilities and childbearing cause married women to drop out. The 1980 study indicates that almost 80 percent of registered nurses in these age groups were employed in nursing. In the 1977 study, the percentage was closer to 70 percent.

While flexible hours and schedules may help accommodate women with family responsibilities in participating in the work force, current information is not available to make a quantitative determination of the net national effect of this factor. This rather dramatic increase of 6 percent in the labor market participation rate in 3 years cannot easily be attributed to any specific factor such as work schedules and flexible hours. Other factors which have been suggested include the growing tendency generally to combine motherhood with gainful employment, an increasing tendency for women to become primary full-time wage earners, and an increase in perceived family financial need.

ADVANCED TRAINING FOR NURSES

Senator SCHMITT. And you might put some editorial comment in that as to how those numbers actually relate to the actual need and whether the numbers of vacancies actually relate to real need.

Dr. GRAHAM. That is a concern of ours also.

Senator SCHMITT. The American Nurses Association says the greatest need today is for nurses with advanced training. If this is the case, how can you justify an advanced training program which provides for a total of seven awards for fiscal 1983?

Dr. GRAHAM. Well, I believe that there is some difference of opinion there between our budget and the Nursing Association in terms of what the highest priority is. The contribution of advanced nurse training has been a major one over the last number of years in terms of providing more nurses that were interested in and capable of doing nursing education and administration. In our judgment, under the present budget constraints, that is simply not an area that we can invest in any longer.

Senator SCHMITT. Is there any relationship between advanced training of nurses and the willingness of doctors and other hospital staff personnel to provide a better professional environment for nurses?

Dr. GRAHAM. None that I would be aware of, sir, because the focus of advanced nurse training really is to provide that additional educational preparation for expanded responsibility in pedagogic areas or administrative areas. The interface where I believe we have most of our issues between physicians and nurses is on the wards in the clinical area.

Although increasing numbers of nurses have different types of advanced preparation in nursing, far and away the vast majority of nurses that are doing bedside nursing come out of a basic preparation at the baccalaureate, associate, or diploma degree level. I am not sure that additional numbers of masters or Ph. D. nurses at the bedside is going to solve some of the issues that exist with the doctors; and, indeed, I believe our experience is—and it is not hard to understand—that the nurse who takes the time, energy and investment to acquire an advanced degree and advanced competency is probably not going to be interested in continuing to serve on an 8-hour shift doing bedside nursing. That is an individual that has evidenced an interest in doing more in nursing, whether it is in administration or teaching or research, than simply the day-to-day patient care responsibiities.

INTENSIVE CARE UNITS AND NURSING CARE

Senator SCHMITT. What about the new hospitals that are coming on line, the new wings that have extremely advanced monitoring care facilities? I know the Presbyterian Hospital in Albuquerque has just opened a new wing that I visited the other day, and there seems to be really a revolution in how nursing care is provided. A fewer number of nurses monitoring a larger number of patients is what appears to be the case. Is that having any significant effect nationally on the demand for nurses or in the need for advanced training?

Dr. GRAHAM. Again, the focus of advanced nurse training, as that program has functioned over the last 5 to 10 years, has not been in providing additional clinical training for nurses, for instance, to take on ICU responsibilities. Whether or not that change in organization of hospitals is leading to a diminished demand for nurses, and I suspect that at the margin it may well be, if you have an ICU that is configured in an open circle rather than a linear model, then you may have three to four nurses who can cover what five to six had to cover before, and the telemetry and additional instrumentation may make a difference.

I am not an expert in this area, but I had better say for the record, if there is better expertise we will submit it here.

[The information follows:]

In the past few years advanced nurse training has included training in clinical areas. During fiscal year 1981, approximately four-fifths of the appropriated funds for advanced nurse training were used to support programs preparing clinical specialists for work in hospital settings. An increasing number of these nurses are working at the bedside, including intensive and critical care units. A number of graduate programs have been taken to geographic areas in which opportunities for advanced clinical preparation were scarce or nonexistent. Evaluation data indicate that 85 percent of these nonurban nurses have remained in the region in active practice and those who left did so because their families moved or because they sought additional educational preparation.

Dr. GRAHAM. My impression from reading a little bit of the literature that I have is that there is some balance on this, and we may be coming back toward the midline. Indeed, some of the newer ICU's that 2 or 3 years ago opened up with all of this very advanced instrumentation and cut the number of nurses markedly are now adding nurses back in, because, what the nurses are saying is that the pressure is just overwhelming, that the instrumentation is there and that indeed you can watch six monitors now where before you could only watch three, and they beep at you when there is an arrhythmia rather than your having to actually see it, but it still means you are trying to cover six very sick patients. That's a load; that is an intellectual and emotional burden.

I think we are seeing some of the institutions now saying we have to take into account the human factors, not just the instrumentation factors.

SUBMITTED QUESTIONS

Senator SCHMITT. We will have quite a number of questions for the record and you will have a chance to return those when you return your corrected transcript.

[The following questions were not asked at the hearing but were submitted for response for the record:]

Questions Submitted by the Subcommittee

BUREAU OF HEALTH PLANNING PROGRAM SUPPORT

Question: How many people are presently employed at the Bureau of Health Planning?

Answer: As of March 6, 1982, the total number of permanent full time employees in the Bureau of Health Planning is 128--89 at headquarters and 39 in the regions. The total number of other than permanent full time employees is five-three at headquarters and two in the regions.

Question: How many people were employed at the Bureau at this time last year?

Answer: As of February 20, 1981, the total number of permanent full time employees in the Bureau of Health Planning was 243--118 at headquarters and 125 in the regions. The total number of other than permanent full time employees was 24--17 at headquarters and seven in the regions.

Question: What further staff cutbacks are planned at the Bureau?

Answer: We are not, at the present time, preparing for a reduction in force (RIF). If by a specific date we are required to be down to a particular budgeted position level, it may be necessary to conduct another RIF. This approach applies to the Bureau of Health Planning and to the agency as a whole.

Question: Has the use of "bumping" procedures interfered with effective staffing of the Bureau?

Answer: The recent RIF and specifically the "bumping" resulted in the displacement of many Bureau of Health Planning employees. In the RIF process the Bureau acquired several new staff with no planning background. While these new staff members are competent and trainable, orientation and training is necessary.

Question: How have various job actions affected morale?

Answer: The major adverse impact of the RIF on morale resulted from the extended length of time of uncertainty and preparation. The prospect of drastic reductions in staff caused several highly skilled employees to obtain employment elsewhere. The Bureau has not been able to replace the level of expertise lost which has had an adverse effect on the morale of those who remain.

Question: What is your comment as to whether, even during this phase out period, the health planning program can operate effectively with this reduced level of personnel and alleged morale problems?

Answer: Resources of 140 full time permanent positions during FY '82 are sufficient to begin the phase out period for health planning. The positions requested for FY '83 will be involved in administering the close out of categorical grant programs, collect funds (due to the Treasury) and dispose of equipment purchased with Federal funds.

HEALTH PLANNING

Question: Is a second look warranted at the health planning program and its accomplishments?

Answer: The Administration continues to believe that the answer to spiraling health care costs is the implementation of a competition strategy and changes in reimbursement practices. For those areas where health planning is needed, we believe that they are more appropriately controlled by State and local governments.

Question: What is your comment to the assertion that an accurate, objective assessment of the health planning program may well be an impossible task?

Answer: A comprehensive assessment of the health planning program would be extremely difficult but not impossible. However, a clear understanding and agreement of what was expected of the health planning program as expressed in P.L. 93-641 would be a necessary prerequisite to such an assessment. The recently issued report by the CBO stated: "It is widely thought that confusion about the mission of the health planning program has limited its effectiveness, or at least has hampered evaluation of its effects. Planning objectives vary across Federal, State and local agencies, among agencies at the same level, and within a single agency." One of the major hurdles in assessment is the numerous objectives--improving access, cost containment, increase availability of care, etc.,--some instances can be described as complex goals diametrically opposed to one another. The lack of agreement on any one objective makes very difficult the assessment of which objective was met.

Second, there is the cumbersome structure imposed by the statute requiring that representatives of the entire community participate. Both the process of selection and the degree of effectiveness provide challenges to any study of the program.

The key factor in any assessment is measuring the degree to which individual planning agencies met the needs of the community. For example, access to care is not a problem in every part of the country; cost containment may be of lesser importance in a rural area where the priority need is availability of health care. Additionally, no data exists for some areas as to agency activities in serving as a community forum and educating principal actors on system problems.

COST EFFECTIVENESS OF HSA's

Question: What data do you have with respect to the cost effectiveness of the activities of health planning agencies?

Answer: Although some local agencies have shown to be quite successful, this success has not been uniform among all HSAs across the country. In 1981, the Bureau collected agency-specific data on the effectiveness of various planning agencies. The most effective cost management achievement of HSAs have been achieved through developing voluntary alliances with local business groups, hospital consortiums, health associations and the local governments. Together these organizations are able to work together to reduce hospitalization rates, negotiate shared services arrangements by local hospitals, increase public awareness of rising health care costs. Examples of these successes are as follows:

In 1979 the Hudson Valley (NY) Health Systems Agency joined local business and industrial leaders to promote interhospital cooperation. The previous year two hospitals within several blocks of each other had developed major capital projects. Initially the agency enlisted the aid of Mid-Hudson Pattern, Inc. to support the agency stand that the hospitals should enter into a cooperative review of the most cost effective alternatives rather than duplicating services. A special committee was formed including executives from IBM, Central Hudson Gas and Electric, Rotron Corp., New York Telephone, Ferroxcube, Hercules, Kingston Freeman, leading commercial and savings banks, and the HSA. The business community, county government and Blue Cross/Blue Shield contributed funds for a joint hospital study. Together, the HSA and Pattern Co. successfully promoted extensive negotiations between the hospitals and in April 1980 the two hospitals reached accord on an extensive shared services arrangement.

Responding to a request for technical assistance from the Central Iowa Health Association, a local business labor-provider coalition, and the Des Moines Area Hospital Consortium, the Iowa Health Systems Agency analyzed hospital discharge data for 1979. The agency discovered that the admission rate and patient day use rate for the Des Moines metropolitan area for the under 65 age group were 12 percent and 17 percent, respectively, above National rates. As a result, the coalition adopted a two-year goal of reducing local hospitalization rates to below the National average. When realized, estimated operating cost savings should be $10.5 million--52,000 patient days x $200 per day--and would be accompanied by capital costs savings related to any reductions in excess bed capacity.

In 1978 the Florida State Health Plan recommended action to determine the feasibility of establishing a rate review program in Florida. The Statewide Health Coordinating Council sponsored a series of hearings and then met with the Secretary of the Department of Health and Rehabilitation Services and the Governor. In response to a request from the Governor, the State health planning agency and the Council sponsored a feasibility study. In December 1978 the Council adopted the recommendations of this study and decided to support the establishment of a hospital rate review commission.

During the spring of 1979, the Florida Legislature held hearings around the State, the Council presented testimony and State agency staff provided substantive information to legislative staff. In May 1979 the Florida Legislature passed the "Health Care Cost Containment Act of 1979" which established a Hospital Cost Containment Board and included most of the Council's recommendations regarding the commission. The board is now operating; it has developed a uniform reporting format for hospital cost and patient data. Initial reporting requirements have been met by the Florida hospitals.

DRAFT REPORT BY CONGRESSIONAL BUDGET OFFICE

Question: What are your comments with respect to the findings of a draft report prepared by the Congressional Budget Office which analyzes the effectiveness of the health planning program in general and the possible savings attributable to certificate of need in particular?

Answer: In general, we think that the CBO report provides a fair assessment of the health planning program. The report recognizes some of the problems that exist with the health planning effort. These include sometimes unclear and conflicting goals that may have limited the effectiveness of the program; the lack of direct authority other than certificate of need to implement goals, the reluctance of hospitals to merge/share services, or otherwise cooperate because of concern that such actions might lead to antitrust problems; and extensive Federal requirements for such things as governing boards and comprehensive health plans which may have absorbed agency resources without improving effectiveness.

The report also recognizes the diversity of State efforts to deal with the problems of cost containment and maintaining access to services. It provides a comprehensive overview of the studies undertaken on the effectiveness of the certificate of need program. The report recognizes the mixed results from these studies, showing progress and advances in particular States, but not showing much of a trend on a nationwide basis.

By presenting options for changing the health planning program, the report should add to the discussions on future health planning directions.

FUTURE OF HSA's

Question: Assuming that the Federal health planning program expires, is repealed, or does not receive funding, what is the timetable for when funding would run out for each of the 200 or so existing HSAs?

Answer: Currently 203 health systems agencies continue to be operational. However, as a result of five States electing to change to Section 1536 States, 27 Health Systems Agencies are in the process of closing down these local operations. We anticipate that an additional 15 agencies will close operations prior to the end of FY '82 and an additional 40 to 50 will close in the first few months of FY '83. The remainder--100 to 120-- will continue operations in FY '83 with the funds provided in FY '82. The end of these grant periods are staggered throughout FY '83 with the last having Federal funding until the end of September 1983.

Question: What do you believe has been the main purpose of the health planning program?

Answer: The purposes of the health planning program are numerous but unfortunately no single purpose has ever been articulated in the law nor agreed to nationwide. A major thrust of the planning program was to assist States and communities in addressing health problems to the best of their ability.

The primary goals of the health planning programs have been to improve the health status, to increase accessibility, acceptability, continuity and quality of health services, to restrain increases in the cost of producing health services, and to prevent unnecessary duplication of health resources.

Question: Why do you believe that health planning has failed in its mission to control costs in the health system?

Answer: The health planning program was not designed to deal solely or directly with the increased costs in the health system. Other factors, such as the general State of economic trends, reimbursement mechanisms, and new technology development, must assume a major part of any blame of health care cost increases. In addition, planning agencies have little authority other than persuasion to deal with these problems. The data on the effectiveness of CON in controlling costs continues to be mixed.

CONTINUING OPERATION OF HSA's

Question: How many HSAs will continue to operate without Federal funding?

Answer: We expect that around 50 local organizations will continue planning activities after Federal funding for planning is eliminated. In addition, the Robert Wood Johnson Foundation has announced a three year, $16 million grant program that will fund 10 to 12 local projects quite similar to HSAs.

Question: What action would be taken by the Department to prepare HSAs for eventual closure?

Answer: The Bureau of Health Planning has developed and issued comprehensive guidelines to the agencies to assist their timely phase out of Federal funding. The Bureau has conducted training sessions for all Regional Office staff to assist agencies in this process. Furthermore, training sessions for agencies will be conducted throughout the country. The existing guidance materials and the training sessions are designed to effect an orderly phase out. Additionally, the Centers for Health Planning will provide agency specific assistance with close out activities.

Question: How long will it be before the current contracts of HSAs expire?

Answer: The first HSA grant awards with FY '82 funds is scheduled to expire November 7, 1982 and the last grant awarded with FY '82 funds will expire September 29, 1983.

Question: How many HSAs have already closed in anticipation of an end to Federal support?

Answer: As of March 16, 1982 we have an indication that 6 HSAs intend to close operation of their own volition.

Question: Have staffing levels in HSAs been reduced in anticipation of withdrawal of Federal support?

Answer: Yes, staffing levels in HSAs have been reduced in anticipating the elimination of Federal support for health planning.

MINIMUM GRANTS FOR HSA's

Question: How many HSAs are not receiving the minimum grant of $100,000?

Answer: Based on a FY '82 appropriation of $37.7 million to provide for 178 HSAs, a total of 60 HSAs will be eligible for funds at the minimum level of $100,000 and 118 will be eligible for funds above the minimum.

Question: Is the minimum grant to HSAs proving sufficient for maintenance of a significant planning effort, or could that money be better spent elsewhere?

Answer: In the absence of significant non-Federal funds, a minimum grant award of $100,000 would not be sufficient for an agency to maintain the minimum staff levels required by the statute.

Question: How many HSAs are receiving contributions from health insurers?

Answer: Since this is a new provision of the Omnibus Budget Reconciliation Act, agencies have been pursing these sources of contributions for a short period of time and we do not have available any hard data on their success.

Question: How many States will fund local health planning in all areas of the State, or only in key areas with unusually high health costs?

Answer: To date a few States are currently considering proposals which would provide some funds to local agencies. However, no States have taken definitive action appropriating funds for local planning to replace the proposed elimination of Federal funding.

HEALTH PLANNING COALITIONS

Question: How many coalitions among business, labor and local government presently exist for health planning?

Answer: There are currently 45 to 50 coalitions which are largely engaged in activities to restrain the increase in the cost of health care. They are largely sponsored by corporations and designed to focus on the costs of care delivered to employees and their dependents. Membership in these groups include local governments in a limited number of cases as major purchasers of health care, and a few have providers as formal members.

Question: What are the merits of such coalitions, and what can be done to encourage the establishment of more coalitions of this type?

Answer: The development of these coalitions is consistent with the Administration's view that health planning should continue at the State and local levels as long as entities at those levels are willing to pay for it. They demonstrate the benefits of coordinating activities at the State and local levels to restrain the increasing costs of health care. Disseminating the successes that these groups have achieved to stimulate interest in them would be an approach to encouraging more coalitions to develop.

Question: How would such business, labor and local government coalitions for health planning interact with State certificate of need programs once the Federal health planning role ends?

Answer: Such interaction would largely depend on the attitudes and preferences of the individual States, and the coalitions themselves.

Question: What is your view as to whether actions of such coalitions for health planning could possibly be regarded as violating antitrust laws?

Answer: Since there are few coalitions which are that active as yet, and since a few of them include formal provider members, it is unclear as yet what the antitrust problems are. It is possible that where there is formal provider participation in systems reform and reimbursement activities, coalitions may run the risk of being viewed as anti-competitive in the sense of dividing up the market, or setting prices. However, antitrust issues will probably not evolve as long as the coalitions restrict their activities to examining/analyzing health care data. Action beyond that may subject the coalition to an allegation of antitrust violation.

HEALTH PLANNING AND ANTITRUST ISSUE

Question: What is your view as to whether the antitrust issue could be a major problem for hospitals once the Federal health planning program is ended?

Answer: The health planning program does not, nor was it intended to, provide protection to health care providers from compliance with antitrust action. Regardless of the presence of health planning, hospitals and other providers will be subject to and may have problems with the antitrust laws.

Question: How would hospitals be able to protect themselves from antitrust suits if they engaged in cooperative, resource-sharing efforts with other institutions once the Federal health planning program is ended?

Answer: This question can only be answered by the courts and the Federal Trade Commission. The degree of cooperation, the extent of resource sharing, and the impact these actions have on competitors and the market place are factors that would have to be considered in each individual case. Hospitals would be subject to the same antitrust provisions that apply to other industries.

Question: How many HSAs have applied for waiver of various review responsibilities, as permitted under the terms of Reconciliation?

Answer: A total of 75 HSAs requested and received a waiver eliminating the requirements to perform their functions.

Question: If the waivered requirements for HSAs were so burdensome, why haven't more agencies applied?

Answer: The Department has eliminated the requirement for submission of a waiver with respect to the performance of these functions through a "blanket waiver" policy. These new regulations were published in the Federal Register on January 26, 1982. We assume the vast majority of the agencies are no longer performing these functions.

Question: Legislation has been introduced in this Congress (HR 3666) to repeal the health planning program, rather than just allowing authorizations to expire. Which approach -- repeal or expiration of the health planning programs -- do you favor and why?

Answer: At this time the Administration believes that expiration of the legislation is preferable to repeal. In addition to the obvious fact that this course of action is administratively a more simple approach, there also will be a number of planning agencies that will continue to receive support into FY '83 based on final grant awards made in FY '82.

HEALTH PLANNING - LOCAL PLANNING AND IMPLEMENTATION

Question: What is the Administration's rationale for proposing the termination of the health planning program?

Answer: The Administration proposes to eliminate Federal funding for health planning as part of its proposal to focus on competition and effect the health care financing reforms. In addition, the Administration believes that health planning can be more responsive and be handled more effectively at the State and local levels. Furthermore, the health planning program is viewed as a regulatory burden on the health care industry. These burdens must be eliminated to foster free market concepts.

Question: How does the Health Resources Administration view the future without HSAs, particularly for underserved areas? Is data available which indicates that communities will pick up the bill?

Answer: We believe that local planning activities will be supported in those areas where these activities are viewed as a priority. We anticipate that approximately 50 local planning agencies will continue some level of operations in the absence of Federal funds after FY 1982.

Question: Please comment on the apparent contradiction between the Administration's position and the conclusion of a recent Institute of Medicine report that the health planning program is worth keeping, although perhaps with scaled-down expectations.

Answer: The Administration continues to believe that funding for health planning should be the responsibility of State and local levels of government. The Federal government will focus on mechanisms designed to promote free market concepts.

HEALTH PLANNING - STATE PLANNING AND REGULATION

Question: State Health Planning and Development Agencies develop State health plans, enact and implement a State certificate of need program, and establish and maintain a State Health Coordinating Council. How effective is the certificate of need process in controlling unnecessary and costly capital investment by hospitals and other health facilities?

Answer: The report of the HRA program review of CON and the recently completed CBO paper "Health Planning: Issues for Reauthorization" examined this issue and stated that there is no available evidence that on a national basis CON alone has had a demonstrable effect on aggregate hospital costs or investments. Both of these reports, however, continue with a note of caution regarding interpreting the evidence to date as being conclusive.

First, the time periods covered by the studies do not allow examination of the long-term effects of CON. The evaluations also reflect provider investment decisions made before implementation of the Federal law and gains made as a result of Federal requirements and funding would not have appeared in the studies.

Second, the studies were designed to measure national average effects. The affects of successful State programs could have been sufficiently diluted to preclude measurement. Certain studies have indicated that some States have been successful at limiting the amount of capital expenditures undertaken and the growth in capacity with a corresponding affect on utilization.

Third, the studies have significant methdological and other technical limitations that may preclude identifying some CON effects. For instance, CON may affect the mix of capital projects with a shift toward those projects favored by health planning agencies because others might be denied. Also, studies to date have generally tended to look at CON in isolation. One recent study indicates that States with stringent CON programs in combination with stringent rate-setting programs have experienced a lower growth in both CT scanners and hospital costs.

COMPETITION IN HEALTH INDUSTRY

Question: What is your comment with regard to criticism that the health planning program in general, and the certificate of need process in particular, act to thwart competition in the health industry?

Answer: Some believe that CON review has prevented construction of new facilities, has presented new entrants from coming into a market, and in so doing has stifled potential competition from proprietary hospitals and from alternative health service delivery systems, such as HMOs. Although there is some anecdotal evidence that CON review has favored nonprofit hospitals over proprietaries, it has not been carefully tested. In one set of legislative amendments, the Congress exempted HMO projects from the CON process, because of this concern.

Question: What, in your view, would occur given the absence of the health planning program?

Answer: I can answer the question in the sense of what will happen when Federal funding of State and local health planning agencies is terminated.

We would expect that most States will maintain some health planning activity even in the absence of Federal support; and as indicated in response to another of your questions, that 30 or so States will continue their certificate of need programs. It should be remembered that under the Federal health planning program all States did provide required matching funds; and in a few instances State funding was in excess of Federal grant support.

At the local level we anticipate that perhaps as many as 50 of the present Health System Agencies will be able to continue operations in some form with non-Federal funding from business and industry, health care insurers, local government, etc. Furthermore, there are some 45 to 50 health coalitions that have been established in recent years which may engage in certain planning related activities.

Total funding for State and those local health planning efforts continuing after the termination of Federal support doubtless will be less. However, since Federal requirements with respect to functions, governance, staffing, and structure tend to absorb agency resources, the elimination of these requirements will offset funding reductions..

CAPITAL EXPENDITURES BY HOSPITALS

Question: Please comment on the allegation that elimination of capital controls would lead inevitably to a capital buying spree by hospitals, thus intensifying the need for some type of regulatory cost control.

Answer: It is quite possible that some hospitals which had been denied certificates of need for certain major medical equipment, e.g., CT scanners, or the establishment of new services, e.g., open heart surgery, or have been discouraged from doing so by virtue of State CON programs, might proceed with such plans were capital expenditures controls to be lifted. Whether that would be described as a "buying spree" is another matter.

Perhaps more to the point is that there has been a significant increase in proposed capital expenditures by hospitals and others in recent years even though all but one State, (i.e., Louisiana), presently have CON programs. For example, in 1981 17 States reviewed proposed capital expenditures in excess of $250 million; and these 17 States accounted for about 75 percent of the proposed capital expenditures reviewed by the 45 reporting States--$10.5 billion out of a total of $14.1 billion. This was more than double the dollar volume of capital expenditures reviewed by those 17 States two years previously, in 1979.

Just 9 of those 17 States accounted for over 50 percent of the total proposed capital expenditure reviewed in 1981--$7.3 billion out of $14.1 billion; and in the aggregate, the dollar volume of reviews conducted by those nine States, i.e., California, Florida, Louisiana, Minnesota, New Jersey, New York, North Carolina, Ohio, and Texas, more than tripled between 1979 and

1981. What we may be seeing in these States now, and perhaps in other States in a few years hence, is a surge in proposed capital expenditures brought about principally by: 1) major replacements of the existing but aging stock of hospitals in certain of the most populous States, (e.g., New York City), 2) significant expansion of existing facilities and construction of new facilities--in response to the rapid population growth in certain areas, (e.g., Florida, Dallas, Ft. Worth), or 3) both replacement amd expansion. Whether this surge in proposed capital expenditures, if it continues, will lead to an intensification for some types of regulatory cost control mechanisms such as CON and rate-review, is a matter of conjecture. If it does occur, it seems more likely to manifest itself in some States before others.

Question: Please comment on recent studies which show that the certificate of need process may be having a more salutory effect on capital costs than had been reported a year ago.

Answer: Certain recent descriptive studies such as those by Julianne R. Howell and Alvin E. Headen, Jr., indicate that CON may have been effective in some States, e.g., Massachusetts, in limiting the amount of capital expenditures undertaken and the growth in capacity with a corresponding limiting effect on utilization. Similarly a recent survey by the American Hospital Association designed, among other things, to obtain information on "the impact of certain regulatory programs on hospitals'...expansion plans," indicated that 20 percent of those which had expansion plans--450 out of 2,168--had dropped or deferred such plans. The principal reasons cited by the hospitals themselves was the CON requirements.

An recent analytical study by Thomas Bice and Nicole Urban, the findings of which have yet to be published, indicates that States with stringent CON programs in combination with stringent rate-setting programs have experienced a lower growth not only in the number of CT scanners but in overall hospital costs as well.

These studies do suggest that CON has been effective in restraining capital expenditures and has had a moderating effect on increases in hospital costs in certain States at least.

CERTIFICATE OF NEED

Question: If the Federal health planning program expires, is repealed, or is not funded, what is your view as to whether the States would, in turn, repeal their certificate of need programs?

Answer: Very few States would immediately repeal their own CON laws or programs when the Federal health planning program expires based on the information and intelligence we currently have. Only a very few States either presently have--Arkansas--or are actively considering,--e.g., Alabama and Colorado, legislation that would automatically repeal or "self-destruct" their CON programs upon expiration of the current Federal CON mandate and requirements.

Although, within a year or two some States might repeal their CON programs, our best current estimate is that about 30 States are likely to continue their CON programs. States most likely to do so are those which had established such programs prior to the enactment of P.L. 93-641 or also have mandatory, Statewide rate review programs and CON is viewed as part of a broader cost containment strategy and program. There are 38 and 9 such States respectively.

CHANGES BY STATES IN CON

Question: What changes in certificate of need do you believe States would make once Federal requirements were lifted?

Answer: Based on legislative changes already made by a few States, proposed changes pending in a number of other States, and the views expressed by selected State officials in the course of a two-day CON program review recently held by the Health Resources Administration, modifications to current State CON programs are likely to: 1) include higher threshold levels: California, for example, has recently revised its CON legislation so as to automatically provide for a $1.5 million, or $35,000 per bed, threshold following removal of the presently required Federal thresholds: 2) limit the scope of coverage: a number of States are considering changes that would exclude nonmedical services such as parking garages, heating and cooling plants, and the like from CON review. Illinois' present CON law provides that coverage of major medical equipment would be automatically dropped when the Federal requirement for that becomes inoperative: 3) streamline program administration and the CON process: some States, for example, will drop the batching requirement given their limited caseload; others will simplify their review process, including the conditions under which public hearings are required and appeals allowed; and instituting CON application fees: sixteen States already levy such fees, and a number of others are considering the establishment of them in order to help defray the costs of administering their CON programs at a time when Federal support is being reduced. 4) Link CON more closely to other health regulatory mechanisms, especially rate review; using CON to create a more competitive environment; basing their programs on "relative" as opposed to "absolute" need, and expanding CON review to include the full cost of health services, not just the capital outlays.

Question: What is your comment as to whether State action to maintain certificate of need would run counter to Administration efforts to deregulate the health system in the interest of stimulating more competition?

Answer: The continuation of CON and other regulatory programs by some States at their discretion and from their own resources, is consistent in principle with the new federalism proposed by this Administration.

Question: How many States have taken advantage of the option provided under Reconciliation to request the Department to eliminate the HSAs within their State?

Answer: A total of five States requested and were approved Section 1536 status. Therefore, the 27 HSAs in those States will cease operations during FY '82. The five States are Louisiana, Ohio, Missouri, Alabama and, Nebraska.

Question: What are the advantages for a State in eliminating Health Systems Agencies?

Answer: States have chosen the 1536 status in order to centralize the States health planning and CON activities rather than through the decentralized HSAs.

HILL-BURTON "FREE" CARE

Question: The Bureau of Health Facilities is responsible for administering the so-called Hill-Burton "free" care provisions. (Any facility which has received assistance under the Hill-Burton program is obligated by law to provide a specified amount of uncompensated services to persons unable to pay for them). How many hospitals and other health facilities remain under an obligation to provide so-called "free" care, or uncompensated services to indigents, as a condition of their Hill-Burton assistance?

Answer: There are 4,814 such facilities as of February, 1982.

Question: How extensive is compliance with the Hill-Burton "free" care provision, now that the Federal government is responsible for enforcement, as opposed to the States?

Answer: The regulations established a Nationwide, uniform reporting system, which requires facilities to report to the Department once every three fiscal years. Facilities are permitted 90 days from the close of their fiscal year to submit the report to the Department. This system is being implemented in three cycles and complete data from all facilities will not be available until late 1983 or early 1984. February 1982 marked the middle of Cycle II of the system. Data obtained from the reporting forms of Cycle I received to date is being entered into a computer system, which will begin producing management reports in the spring of 1982.

Question: How many States have availed themselves of the option of assisting in enforcement of the Hill-Burton "free" care provision?

Answer: Six States have elected to take this option. They are California, South Dakota, Montana, Minnesota, Ohio and Vermont. While the regulations do allow the Department to enter into these agreements with those States that are willing and able to assume certain administrative responsibilities, there are no funds appropriated to the States for doing this. It appears unlikely that many more States will elect to enter such agreements without funding support.

ENFORCEMENT OF "FREE" CARE REQUIREMENTS

Question: Is there any overlap between people who get uncompensated services under the Hill-Burton "free" care provision and persons covered by Medicaid? If so, how does a hospital handle Medicaid charges for services provided to indigent patients eligible for Hill-Burton "free" care?

Answer: The uncompensated services regulations preclude a facility from counting toward its obligation for uncompensated services obligated any amounts that it receives or is entitled to receive from third party insurers or governmental program including Medicare and Medicaid. A facility may count toward its obligation for uncompensated services the allowable credit for Medicaid eligible individuals when Medicaid benefits expire.

Question: How many complaints from indigent persons unable to receive Hill-Burton "free" care have been received and settled by the Department since it began enforcement of the "free" care regulations?

Answer: Over the years we have received about 1,032 active complaints, including 350 prior to FY '79, 279 in FY '79, 253 in FY '80 and approximately 150 for the first three quarters of FY '81. Data is not currently available for FY '82. Many of the complaints received in or prior to FY '80 concerned compliance with the earlier regulation rather than the one promulgated by the Department in FY '79. Since then, decisions have been rendered on approximately 56 complaints and approximately 150 have been dismissed without findings or withdrawn. The Department's Regional Offices also receive many inquiries from individuals who intend to file complaints. By providing program information material to these individuals, or by contacting the facilities involved, formal complaints are avoided. The Department estimates that the number of formal complaints received annually would be substantially higher in the absence of such "informal negotiations."

Question: How many Hill-Burton aided hospitals are in areas (such as certain high-income suburbs) with so few indigent persons that these hospitals are unable to fulfill their quota for uncompensated services?

Answer: The Bureau has not yet received sufficient data to show how many facilities are unable to meet their uncompensated services obligation due to a lack of community needs. Some of this information is expected to be available sometime this Spring when the uniform assurances monitoring system is implemented.

Question: Please provide a breakdown, on a State-by-State basis, of each individual hospital's annual obligations for Hill-Burton "free" care and the extent to which each individual hospital has complied with its obligations--both currently and in the past.

Answer: We will submit, separately to the Subcommittee staff those breakdowns we have available. It is, however, important to remember that the regulations set a facility's annual compliance level at the lesser of 10 percent of all Federal assistance received within the twenty year period of obligation or 3 percent of its operating costs less Medicare and Medicaid reimbursements. The breakdowns we have available will only tell you the individual facility's total Federal assistance. We do not have information as to the individual facility's obligation for 3 percent of operating costs. Information about each facility's dollar obligation and the extent to which each individual hospital has complied will be available when the uniform assurances monitoring system is fully implemented. As I stated in my answer to an earlier question, the regulations in 1979 established a uniform reporting system requiring reports from facilities every three fiscal years.

Question: What consideration is the Department giving to revision or even withdrawal of the 1979 Hill-Burton "free" care regulations?

Answer: An outgrowth of the recent activities of the Secretary's Task Force on Hospital Deregulation is an expected publication of a Notice of Proposed Rulemaking to amend certain portions of the uncompensated services regulation. I am unaware of any active consideration of an option to withdraw the present regulation.

DOLLAR AMOUNT OF "FREE" CARE

Question: What is the total dollar amount of so-called "free" care provided by facilities with a Hill-Burton obligation, and how many patients benefit?

Answer: It is estimated that the total dollar amount of uncompensated services provided annually is $450 million. Each facility may establish its own allocation plan for providing uncompensated services. It may limit such services to specific areas such as a burn unit or outpatient department. There is no data available as to the number of patients benefiting from these services. When the assurances monitoring system is fully implemented such information will be available.

Question: What efforts are being made--by the Federal government or the States--to see that hospitals make a real attempt to seek out and assist potential patients who are indigent and qualify under the Hill-Burton "free" care terms?

Answer: Under the regulations, a facility is required to publish a notice of its uncompensated services obligation in a newspaper of general circulation in its general area. Additionally, each facility must post notices in English and Spanish of its obligation in appropriate areas, including the admissions area, the business office and the emergency room. Each facility is required to provide an individual notice of its uncompensated services obligation to everyone seeking services and each facility must provide a copy of the published notice to the

Health Systems Agency for the area. These requirements are monitored closely in the Department's monitoring and enforcement processes.

Question: What consideration has been given to returning to the States the primary responsibility for monitoring the Hill-Burton "free" care provision?

Answer: As I stated in response to an earlier question, while the regulations allow the Department to enter into agreement with States that are willing and able to assume certain administrative responsibilities, the existing statute places the primary responsibility for monitoring the uncompensated services program with the Federal Government. Since there are no funds available to the States to do this, it appears unlikely that many more States will elect to enter into such agreements without an adequate source of funding support.

MEDICAL FACILITIES GUARANTEE AND LOAN FUND

Question: As $22 million was appropriated last year with the understanding that this amount was sufficient, due to unobligated balances plus anticipated loan requirements, why is it necessary to request an additional appropriation of $10 million for this fund for fiscal 1983?

Answer: Interest subsidy payments each fiscal year are approximately $32 million. Because previous appropriations to meet these obligations resulted in carryover balances, no appropriation was requested in FY '81 and only $22 million was required in FY '82. An appropriation of $32 million is required to pay interest subsidy payments in FY '83 because no significant carryover is anticipated from FY '82 to FY '83.

Question: How long will it be necessary to make interest subsidy payments under this program?

Answer: The standard period for loan amortization is 25 years, and since the last loan closing was scheduled for 1981, a mandatory interest subsidy will have to be paid until the year 2006.

ADEQUACY OF PHYSICIAN SUPPLY

Question: The Graduate Medical Education National Advisory Committee, in its projections of adequacy of physician supply in 1990, estimated that this country will have a sufficient supply of family physicians to meet estimated requirements only if then-existing (1980) levels of Federal support were maintained. But your request is for further reductions in Federal support of family medicine training programs. How does this jibe with the GMENAC projections?

Answer: The objective of assisting in maintaining the 1980 level of production of family physicians, as indicated in the GMENAC Report, remains a Federal priority. However, the primary care budget, including family medicine funding is being reduced, as are most Federal programs, due to overall constraints on the budget

DISADVANTAGED ASSISTANCE

Question: The Disadvantaged Assistance program helps students from disadvantaged backgrounds in gaining admission to and completing health professions training. To what extent are students from disadvantaged backgrounds increasingly deterred from undertaking and completing education for one of the health professions because of the increasing costs of this education?

Answer: The increasing costs of a health professions education are a deterring factor to some students in undertaking and completing education in these fields. The average resident tuition for public medical schools is $2,300 per year; the current average tuition for private is $9,300 while in 1975 the corresponding average tuition costs were $1,200 and $4,400 respectively. Using medicine as the example, there were 42,624 applicants for the first year class in 1974-75; five years later there were 6,000 fewer applicants. However, while the cost of medical school affects the number of annual applications, workforce supply and demand factors also contribute to an individual's decision on whether to apply to medical school.

Question: How many more students will be assisted with the requested increase of $358,000 for fiscal 1983?

Answer: The number of students supported, approximately 23,000 in both structured and unstructured programs, should remain relatively constant from FY 1982 to FY 1983 although there will be a decrease in the number of projects supported.

Question: How many students were helped to completion of their curriculum in health professions education through this program last year?

Answer: The Disadvantaged Assistance program assisted approximately 26,000 students in FY 1981. Approximately 10,000 of these students were enrolled in formal or structured academic programs with curriculums targeted on successful admissions tests or retention in professional training. Another 16,000 students received one-on-one counseling, tutoring or follow-up services. Many other students received information and encouragement because of the presence of Disadvantaged Assistance projects but are not counted as participants.

Question: What is the percentage of total minority enrollment in medical schools supported by grants under this program compared to nonsupported schools?

Answer: Of the 5,503 under-represented minorities, Blacks, American Indians, and Hispanics, enrolled in U.S. medical schools during academic year 1981-82, 3,130 or 56.9 percent were enrolled in grant-supported schools. Not all of these students are served by retention activities of the Disadvantaged Assistance project, but supported schools have enrolled a higher proportion of the target under-represented minority applicants. The race/ethnic breakdown is shown in the following table:

Enrollment of Underrepresented Minorities at U.S. Medical
Schools and Status of Disadvantaged Assistance Funding
Fiscal Year 1981 Academic Year 1981-82

		Funded					
	Total Number	Includes HBCU 1/ No.	Includes HBCU 1/ %	Excludes HBCU No.	Excludes HBCU %	Not Funded No.	Not Funded %
Medical Schools	126	46	36.5	43	34.1	80	63.5
Enrollments:							
Blacks	3884	2334	60.1	1461	37.6	1550	39.9
Indians	229	88	38.4	81	35.4	141	61.6
Hispanics 2/	1390	708	50.9	699	50.3	682	49.1
Total	5503	3130	56.9	2241	40.7	2373	43.1

1/ Historically Black Colleges and Universities: Howard, Meharry, and Morehouse.

2/ Includes only Mexican-Americans and mainland Puerto Ricans.

PUBLIC HEALTH CAPITATION

Question: What is the status of the legislative proposal to repeal capitation assistance?

Answer: The Administration's proposal to repeal the authority for capitation grants to schools of public health is one of a group of legislative proposals currently under discussion between the Department of Health and Human Services and the Office of Management and Budget. We expect to send a draft bill to the Congress soon. The President's budget for fiscal year 1983 includes no funds for public health capitation grants.

Question: To what use are capitation grants now being put?

Answer: Capitation grants have been awarded to accredited schools of public health to provide comprehensive public health training, specialized consultive services, and technical assistance in public health in the administration of State and local health programs. They have provided a mechanism for permitting the schools to undertake increased and newly directed training and service responsibilities.

How many schools and students currently benefit from this program?

Answer: Twenty-two (22) schools of public health, with a combined enrollment of 6,800 students, received FY 1981 capitation grants.

PUBLIC HEALTH/HEALTH ADMINISTRATION SPECIAL PROJECTS

Question: These funds are proposed to be targeted to enhance high priority training programs in five areas. How were these targeted categories chosen?

Answer: Funds will be targeted to enhance high priority training programs for: environmental health professionals to identify, solve and manage problems related to biological, chemical and physical agents in the environment which are hazardous to human health; for epidemiologists and biostatisticians to identify and provide solution to infectious and chronic disease problems and environmental and behaviorally related disorders; for Public health nutritionists, educators and other specialists to address the unique health problems of children, the aged, and the disadvantaged; for administrators of health services systems to provide effective and efficient management while containing costs and maintaining quality; and other emerging public health issues of high priority which contribute to disease prevention and health promotion initiatives.

These areas were chosen to support the Administration's objective of improving the health status for all Americans through disease prevention and health promotion activities as addressed in the report to Congress, entitled, Public Health Personnel in the United States, 1980.

GRADUATE PROGRAMS IN HEALTH ADMINISTRATION

Question: Do statistics show that there no longer exists a need to train health or hospital administrators?

Answer: Current data indicates that the aggregate national supply of health administrators is not a serious problem.

Question: Will such administrators now be trained through the Special Project activity?

Answer: Yes, the same graduate programs in health administration that have received support under this authority will be eligible to apply for special project grants under the proposed new Public Health/Health Administration Special Projects authority requested in the FY 1983 President's Budget.

Question: How will the training program for hospital and administrators under Special Projects differ from what was offered under Graduate Programs in Health Administration?

Answer: Under the institutional support program for graduate programs in Health Administration, grants were awarded on a formula basis to accredited graduate programs in health administration, hospital administration and planning. They were awarded equally to eligible programs. The new Public Health/Health Administration Special Project grants, proposed in the FY 1983 President's Budget, would be awarded on a competitive basis to strengthen high priority graduate programs. They would provide a resource for effecting change in educational programs, responding to demands for development of greater depth and range of expertise among graduates, and introducing needed curriculum components in high priority training areas.

Question: Will similar numbers of students be trained under the Special Projects activity as were trained under the Graduate Programs in Health Administration activity?

Answer: It is not anticipated that the proposed change in training grant authority will have any effect on the number of students trained in health services administration. In requesting funds for special projects, the Administration is seeking an essential source of support for curriculum development, and for certain other activities which will address specific high priority training needs.

Question: What statistics are available to indicate the number of hospital administrators which will be needed in 1990?

Answer: In recent years, educational programs and graduates have grown so that in 1980 approximately 2,000 baccalaureate and 2,000 master's degrees in health services administration were awarded. Hospitals have been the major employers of these graduates, but in recent years this market has become tighter. In the Second Report to the Congress on Public Health Personnel in the United States, 1980, it was estimated that new positions, technological obsolescence among current personnel, and attrition will create an annual demand for 685 new graduates for hospital work in 1981. Since the number of hospitals remains fairly constant, the demand for hospital administrators in 1990 is also expected to remain about the same.

Similarly, the Second Report to Congress concluded that upper-level assistant and associate hospital administrator positions appeared to be limited, and that the supply of master's-trained graduates in hospital administration exceeded current demand. Despite the tighening of the hospital market, we can expect additional jobs to be created in non-hospital settings, such as long-term care and mental health facilities, HMOs, and private industry. The critical, yet unresolved, question is the magnitude of these non-hospital opportunities.

HEALTH ADMINISTRATION TRAINEESHIPS

Question: Grants are awarded to public or nonprofit educational institutions (but not schools of public health) to support graduate study in health administration, hospital administration or health policy analysis and planning.

According to a 1975 report issued by the Commission on Education for Health Administration, only 25 percent of the practicing health administrators had any formal education in that field. An advance copy of a report entitled "Public Health Personnel in the U.S., 1980" suggests that only 34 percent of the current workforce in health administration have appropriate training. While we appear to be making progress, how do you propose we continue if graduate programs and traineeships in health administration are eliminated?

Answer: While there has been no recent definitive study of supply and requirements for health administrators, a great deal of relevant information is know. Taken togther, these sources indicate that there is no aggregate, national shortage of health administrators, and that the total supply is no longer a problem. The Administration proposes, therefore, to direct Federal funds to these higher priority fields to support and improve the training of personnel through the Public Health Traineeship and Public Health/Health Administration Special Project Authorities identified in the President's Budget for FY 1983.

Question: By what method do you propose to attract enough qualified people to enter the field of health administration?

Answer: The field of health services administration is viewed as a highly prestigious and sought after profession for which a degree from a graduate program is the most widely recognized as necessary preparation for entry. The majority of applications for graduate training are submitted to accredited programs where approximately 40 percent of all applicants are accepted. The Administration does not anticipate that the training grant changes proposed will affect the number of qualified people seeking to enter the field.

Question: As more responsibilities are being transferred to States and localities, what would be the effect of eliminating programs to help prepare individuals to better manage the system?

Answer: The number of students enrolled in U.S. graduate programs in health administration increased from 4,080 in 1977 to almost 6,000 in 1980. The number of graduates from graduate-level programs in reaching approximately 2,000 annually. While hospitals had been the major employer of these graduates, in recent years this market has become tighter and graduates tend to be more receptive to entering State and local agency positions, long term care facilities and planning bodies. The Administration does not anticipate that the proposed changes in training grant programs will significantly affect the supply of graduates or their work settings.

Question: As about 25 percent of the country's acute care hospitals are relatively small institutions, located in primarily rural areas, what do statistics show as to the percentage of practicing health administrators with a formal education in health administration in such institutions?

Answer: The Commission on Education for Health Administration reported that in 1976, the most recent year for which data are available, 55 percent of all hospital administrators had some type of graduate degree, although not necessarily in health administration. The Commission further predicted that 90 percent of all hospital administrators would have graduate degrees by 1990.

Although no comprehensive national studies exist, it is widely thought that administrators of small rural hospitals and other rural health institutions have considerably less formal education than their counterparts in larger metropolitan areas.

NURSING PROGRAMS

Question: What have been the findings of the Institute of Medicine's study on nursing and nursing education?

Answer: There are no specific findings of the Institute of Medicine's study as yet. The first report on the study, which was a six month interim report, only raised preliminary issues and provided for the development of the study plan.

Question: What action does the Department intend to take regarding the findings of the Institute of Medicine's study on nursing and nursing education?

Answer: The Department will continue to monitor the progress of the Institute of Medicine study and will formulate its strategy to respond to the findings at the end of the two-year study period. The Department will then have the opportunity to address these issues in a separate report to Congress, which is due in response to the final Institute of Medicine's report at the end of the two-year study period.

ADEQUACY OF NURSE SUPPLY

Question: How would you characterize the Administration's position with respect to the adequacy of the present supply of nurses?

Answer: The Second Report to Congress concluded that the aggregate supply of nurses would be roughly equal to the aggregate requirements in 1985. The Administration's principal concern is being directed toward problems of improved utilization and distribution of nurses and of increasing the numbers of nurses providing bedside care. While there is an acknowledged problem with shortage of nurses in certain work settings and locations, the availability of target funds will assist training institutions and hospitals to develop innovative solutions.

Question: What areas of the Nation are experiencing a nursing shortage?

Answer: There are many dimensions to the shortage of nurses. There is an uneven geographic distribution of registered nurses among States and among counties within States. Inner cities and rural areas lack sufficient nursing services despite the fact that the number of nurse practitioners in rural areas has increased. Achieving a more equitable distribution of nurses is, however, dependent upon factors other than the willingness of the nurse to locate in underserved areas.

Question: Are there certain types of health facilities which have difficulty in recruiting nurses?

Answer: Data shows that there are considerable vacant registered nurse positions in hospitals and nursing home facilities. This would indicate that these settings experience difficulty in recruiting nurses. Some of the negative factors in recruiting are location, salary, and undesirable shift work.

Question: What actions is the Department taking to change certain basic conditions, such as low salaries, which contribute to the nursing shortage?

Answer: There are a number of factors beyond the purview of the Federal government which contribute to the nurse shortage in specific geographic areas and settings such as low salaries, lack of autonomy, "burnout", lack of opportunity for upward mobility, and work pressures resulting from insufficinet staff. The Administration takes the position that these problems need to be addressed by the profession and by the hospitals. The Administration's principal concern is now directed toward problems of improved utilization and distribution of nurses and of increasing the numbers of nurses providing bedside care. While there is an acknowledged problem with shortages of nurses in certain work settings and locations, the availability of target funds will assist training institutions and hospitals to develop innovative solutions.

STATE INVOLVEMENT IN NURSE SHORTAGE

Question: What activities can States undertake to change conditions underlying the nursing shortage, and how can the Department further encourage State involvement in this area?

Answer: In the next phase of its study, the Institute of Medicine will carry out the following activities: First, consult with State government officials and with other policymakers, ascertain how funding constraints are likely to affect nursing education over the next few years, and whether these effects will differ among the different types and levels of education.

Second, obtain additional information from States regarding the extent to which nursing students are dependent upon Federal and non-Federal sources of financial support.

Third, rely on information that has been developed at the State level and by individual institutions in order to estimate the relative costs of the different types of nursing education and to compare nursing education costs to those of other kinds of education, both general higher education and education in other health professions.

And fourth, once this information is available States will be in a better position to determine strategies to alleviate the nursing shortage through changes in educational thrusts. The Health Resources Administration provides consultation to States and has supported groups to work with States to find ways to improve nursing services and nursing education.

Question: What nursing schools are in danger of closing due to decreased Federal aid?

Answer: The Department has no way of knowing which schools may close. We have learned that some schools are considering closing but not necessarily because of decreased Federal assistance.

Question: How much support do States currently provide to nursing education? Do you believe States are currently in a position to undertake further funding of nursing education to compensate for Federal cutbacks?

Answer: Complete data on the amount of money States currently provide to support nursing education is not available. The extent to which the non-Federal sector will be able to assume responsibility depends somewhat upon the type of program.

Question: To what extent do you believe third party payers could be expected to increase their role in the funding of nursing education?

Answer: We have found no evidence to support that third party payors can be expected to increase their role in the funding of nursing education. Hospitals are reimbursed for their nurse training costs based on the Medicare-Medicaid utilization rate.

Question: How many nursing special projects have been eliminated due to the proposed funding cutbacks?

Answer: No projects have as yet been eliminated. Continuation special project grants could be funded at a 30% reduction at the proposed budget level.

PRIORITY FUNDING IN NURSING SPECIAL PROJECTS

Question: What nursing special projects would receive priority funding?

Answer: The projects which carry out one or more of the following designated purposes will receive priority funding: to increase nursing education opportunities for individuals from disadvantaged backgrounds; to provide continuing education for nurses; to help increase the supply or improve the distribution, by geographic area or specialty group of adequately trained nursing personnel needed to meet the health needs of the Nation, incuding the need to promote preventive health care; to provide appropriate retraining opportunities for nurses who desire to re-enter the nursing profession; and to provide training and education to upgrade the skills of licensed vocational or practical nurses, nursing assistants, and other paraprofessional nursing personnel.

Question: Also, how can you justify the elimination of the Professional Traineeship program which is designed to support students in graduate school?

Answer: The Administration believes students should contribute a greater share to the cost of education. FY 1983 funds will be used for programs addressing high priority issues such as improving specialty and geographic distribution of health practitioners and health promotion and disease prevention activities.

RNs--ADVANCED DEGREES AND TRAINING

Question: How many RNs presently hold degrees beyond the baccalaureate level?

Answer: Currently, 65,862 registered nurses hold degrees beyond the baccalaureate level.

Question: What are your estimates of how many RNs will be needed by 1985 with advanced training:

Answer: Although an exact figure for the number of RNs needed with advanced degrees in 1985 in unavailable, at least one study indicates that by the end of the decade, over 200,000 registered nurses with advanced training will be needed.

Question: If two major areas of concern are geographic maldistribution of nurses and providing retraining and continuing education opportunities for those RNs who have left the profession and want to come back, why are reductions being sought in the Special Projects program which is set up to address these needs?

Answer: The overall 1983 budget request is consistent with new legislation and constrained fiscal resources to target Federal resources to promote National priority objectives in health professions training and development. Improving geographic distribution of nurses and providing retraining opportunities for those RN's desiring to re-enter the workforce are two of the five special purposes in Nurse Special Project authority. In the 1983 budget request for Nurse Special Projects, 20 percent of funds appropriated will be allocated for improving the geographic distribution of nurses in underserved areas and a portion of the funds appropriated will be directed toward projects which retrain nurses re-entering the nursing profession.

Question: Under the current nursing student loan program, what is the average family income of a loan recipient?

Answer: The Health Services Administration, of this Department does not currently maintain family income data for these loan recipients. The nursing schools are directly responsible for administering these loans based on demonstrated need. The needs test is based upon a number of factors which include tuition, fees, room and board to attend any one of the over 1,000 nursing schools as well as factors related to each individual's particular family's circumstances.

Question: If Nursing Research Grants are being used to study incentives for attracting inactive registered nurses into the workforce, and this problem is a priority, why are no funds being requested for fiscal 1983?

Answer: Because of financial constraints, the Administration is relying on the Nursing Special Project program to provide new and innovative approaches to address this issue.

NURSING PROGRAM - STUDENT ASSISTANCE

Question: Nursing programs providing student assistance are comprised of the Professional Nurse Traineeship program, the Nursing Fellowship program, and the Nursing Research Grant program, all of which are proposed for no funding in fiscal 1983. To what extent is there a shortage of qualified nurses to teach in the various fields of nurse training?

Answer: Vacant nurse faculty in budgeted positions are reported by the National League of Nurses to be 710 positions in 1980.

Question: How do you anticipate the reduction in funding for nursing student assistance will affect the ability of nurses to pay for their graduate nurse training?

Answer: We have no information at this time as to the effects of the student assistance reductions. Certainly some students will incur larger debts and some sharing of costs can also be anticipated in order for the students to complete their training.

FINANCIAL DISTRESS

Question: For how long have Meharry (Dental and Medical), Tuskegee and Xavier received financial distress assistance from the Department?

Answer: All four of these schools have received financial distress assistance for ten years.

Question: Please outline some of the improvements these schools have made in their operations toward the goal of financial solvency within the last year.

Answer: Some improvements made by these schools are outlined as follows:

Xavier University College of Pharmacy

Efforts to improve managerial systems and procedures, in both the University and the College, have yielded significant results. Improved fiscal procedures have produced increasingly realistic budgets and accountability and responsibilities have been clarified at all levels through a series of management retreats and seminars held throughout fiscal year 1981. In the College of Pharmacy progress is evident in the areas of student records, admissions and counseling--functions that were formerly performed exclusively by the University. The overall College of Pharmacy's budget has increased and economies associated with a central student records system have been achieved. The College has initiated activities to increase income through expanding fund raising efforts, generating additional tuition income, increasing State support and adding sponsored programs.

Tuskegee Institute School of Veterinary Medicine

The School and the Institute are undertaking specific steps to improve management and alleviate financial distress. The School projects a gradual and consistent increase in tuition revenue, in as much as student enrollment has increased annually, the dropout rate among enrolled students is low and tuition has been raised gradually. Tuskegee Institute recently installed a new President who has convened consulting teams to review the Institute's administrative and management structures. The results of these studies are not yet available.

The School is strengthening the staff of the Veterinary Teaching Hospital. Ultimately the Hospital plans to employ specialists with board certification in the fields of orthopedics, surgery, internal medicine, ophthamology, and cardiology. The development of a competent specialized staff will allow the Veterinary Teaching Hospital to enlarge its referral practice and thereby generate more referral income.

Two areas to which the School has paid particular attention are controlling staff and faculty salaries and recovering indirect costs. In April 1980, the School hired a consultant to study cost containment and subsequently hired the accounting firm of Touche Ross and Company to study the issue of equitable allocation of indirect costs. Furthermore, the School is undertaking management studies to identify areas in which operations can be economized.

Meharry Medical College School of Medicine and School of Dentistry

Meharry Medical College has incorporated management reform recommendations advocated by a peer management review team and the Secretary's Task Force. These reforms are in various phases of implementation. On March 20, 1980, Meharry concluded a Management Agreement with the Department of Health and Human Services (DHHS). The Management Agreement establishes conditions with which the College must comply to continue to participate in DHHS contract, loan, grant and cooperative agreement programs. Special assistance to implement operational, managerial and financial reforms are incorporated into the agreements. Included are the employment of additional trained administrative and fiscal personnel to manage all funds received from the DHHS and the designation of a single person as an institutional focus for non-Federal fund raising activities. An accounting firm and a consulting firm are to be hired for specific activities. The College must develop a plan for hiring qualified key management personnel, instituting accounting system changes and developing long term financial plans.

The School has decentralized its organizational structure to increase cost effectiveness of activities, implement cost-containment measures and increase income. As part of the cost-containment activities, the School is rotating house staff with non-Meharry clinical facilities to decrease direct costs, receiving compensation from the George W. Hubbard Hospital for the supervisory activities of certain clinical faculty, and implementing a campus-wide energy conservation program. The School also has implemented an incentive program for faculty members to partially support their salaries by obtaining productive research and service grants which address the problems of better health care, better cost-containment and increased productivity. Finally, tuition has been increased and a private fund raising campaign has been initiated and the School's ability to attract funds from several private foundations has been demonstrated. Another specific activity includes establishment of an Academic Council with responsibility for planning and priority determination.

FAMILY PRACTITIONERS

Question: To what extent have we begun to increase the supply of family practitioners?

Answer: The supply of family/general practitioners is increasing. In 1970 there were 57,948 of these active specialists and by 1980 the number increased to 62,900.

Question: To what extent have we begun to see family practitioners electing to locate in rural areas and small communities?

Answer: Evidence currently available indicates that family practitioners do tend to locate in non-metropolitan and shortage areas in distinctly higher proportions than other physicians.

MANPOWER SUPPLY AND DISTRIBUTION ANALYSIS

Question: The Manpower Supply and Distribution Analysis program provides information on health professions supply, distribution and utilization to assist in evaluating national health policy decisions. How much of the work done under this program is performed "in-house" by the permanent staff of HRA, and how much work is contracted out?

Answer: "In-house" responsibilities combined with contract activities complement each other and are an integral part of the one overall analytical program. For example, the monitoring of practice locations and delivery patterns and of educational developments in the many health professions, the continuous assessment of geographic developments, the development of supply and requirements forecasts, the preparation of analytical reports, and the designation of health professions shortage areas are all done "in-house" by the permanent staff. The contract funds are used for such things as the purchase of data, the maintenance and updating of the many data files--including the Area Resource File, the conducting of surveys, and some of the highly technical research that supports the program's analytical activities. Since the in-house work program encompasses analyses of developments and projections in several dozen health occupations, for both education and care delivery developments in their multiple care settings--such as offices, hospitals, nursing homes, clinics, HMOs, laboratories, and public and community health settings--these contract funds are an essential adjunct to the in-house program. This multi-faceted approach allows the program more flexibility and results in it being more cost effective. In gross terms, we estimate that an equal amount of person-years of effort is used for contract activities as compared to "in-house" staff effort.

Question: Why can't you do it all "in-house"?

Answer: Our experience has shown the most effective and economical way to carry out the responsibilities of this program is through a combination of "in-house" and contract activities. A major factor is that some of the work of the program calls for special expertise and skills at erratic and short term intervals. For example, a particular research project may require several health economists knowledgeable in labor markets but only for a very short period, or a survey project may call for several statisticians, computer programmers, and survey clerical personnel whose particular skills were not needed before or after the survey. Another factor is that many of the in-house analyses use data collected by professional organizations. A third factor is that a major role of the program is to prepare issue-related analyses and reports required by the Department and the Congress. Our experience has been that staff efforts can most effectively be used to identify major issues that can be addressed appropriately by contracts, and then to develop, evaluate, and utilize the findings of these contracts in the high priority analytical context of a broad, policy nature. In past years, the in-house contract activities have provided the framework and data support for this work. Thus, both contract and "in-house" work are essential if the program is to meet all the analytical needs of the Department and Congress on a timely basis.

PHYSICIAN ASSISTANTS

Question: Physician assistants mainly practice primary medical care. Data indicate that they locate in health personnel shortage areas more often than physicians. To what extent is it true that physician assistants have a better record than doctors in locating in underserved areas?

Answer: According to a statement by the Association of Physician Assistant Programs in July 1979, physican assistants practice in non-metropolitan areas more frequently than physicians. In addition, the GMENAC Report on Geographic Distribution of Physicians and Physician Extenders states "Data suggest that non-physician health care providers favorably affect the distribution of medical services by their tendency to select shortage area locations more frequently than is the case with physicians."

Question: What system, if any, is in place to help physician assistants locate an underserved area in which to serve?

Answer: Physician assistants (PA) training programs funded under Section 783 of the PHS Act are required to have placement mechanisms for their graduates as part of their training grant program. Physician assistant programs also expose their trainees to a variety of practice settings through their preceptorship components of the educational programs. These settings include urban underserved areas and PA clinics as well as rural areas. Once preceptorships are established in rural areas, they tend to serve as future preceptorship sites and potential employment sites. Moreover, the curricula of most PA training programs include a class which addresses perspective and aspects of health care. This class may explore all types of settings--rural, urban, institutional and others.

In addition, the graduate placement mechanisms of programs place PAs in varying settings. State PA chapters advertise job openings in newsletters. In some States, such as Washington and North Carolina, the State Medical Society provides administrative services for the PA Chapter fostering a close relationship between the State's physicians and physician assistants. The American Academicy of Physician Assistants also disseminates information about underserved areas and their designation to the State Physician Assistant Chapters. Moreover, the Academy acts as a clearinghouse for information about the Rural Health Clinic Services Act and its impact on PA practitioners.

Question: What percentage of the total cost of training a physician assistant is provided by the Federal Government and what percentage is paid for by the trainee?

Answer: Data on the Federal contribution to the total cost of training a physician assistant are not available. However, the Federal Government is supporting 75% of all physician assistant programs approved by the American Medical Association. It is estimated that the range of Federal support is from 50 to 90 percent of the total cost of a program.

Question: What evidence is there that the number of people entering the physician assistants field would be lessened if Federal aid were to be reduced?

Answer: In the aggregate, data are not available to indicate the extent of decrease in the number of individuals entering the physician assistants field with reduced Federal support. Some individual projects do show that when funds requested are not provided, the number of trainees involved decreases.

SUBCOMMITTEE RECESS

Senator SCHMITT. I appreciate your being with us, Dr. Graham, and your associates. We will recess until Monday, March 15, when we will have hearings on the Department of Labor supplemental request.

[Whereupon, at 10:05 a.m., Firday, March 12, the subcommittee was recessed, to reconvene at the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

FRIDAY, FEBRUARY 26, 1982

U.S. Senate,
Subcommittee of the Committee on Appropriations,
Washington, D.C.

The subcommittee met at 10 a.m. in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Arlen Specter presiding.

Present: Senator Specter.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Assistant Secretary for Health

STATEMENT OF EDWARD N. BRANDT, Jr., M.D., ASSISTANT SECRETARY FOR HEALTH

ACCOMPANIED BY:

- **WILFORD J. FORBUSH, DEPUTY ASSISTANT SECRETARY FOR HEALTH OPERATIONS AND DIRECTOR, OFFICE OF MANAGEMENT**
- **HAROLD MARGULIES, M.D., ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH RESEARCH, STATISTICS, AND TECHNOLOGY**
- **DONALD GOLDSTONE, M.D., ACTING DIRECTOR, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH**
- **FRANK H. SEUBOLD, Ph. D., DIRECTOR, OFFICE OF HEALTH MAINTENANCE ORGANIZATIONS**
- **MARJORY MECKLENBURG, DIRECTOR, OFFICE OF ADOLESCENT PREGNANCY PROGRAMS**
- **J. MICHAEL McGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION**
- **JOANNE LUOTO, M.D., ACTING DIRECTOR, OFFICE ON SMOKING AND HEALTH**
- **JOHN D. MAHONEY, CHIEF, BUDGET BRANCH, PUBLIC HEALTH SERVICE**
- **ELLEN S. WORMSER, DIRECTOR, DIVISION OF HEALTH BUDGET ANALYSIS, OFFICE OF THE SECRETARY**
- **C. CARSON CONRAD, PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS**

SUBCOMMITTEE PROCEDURE

Senator Specter. Good morning, ladies and gentlemen.

The appointed hour having arrived, we shall proceed with this hearing of the Subcommittee on Labor, Health and Human Services, and

Education of the Appropriations Committee. This morning we will hear testimony from the Office of the Assistant Secretary for Health, and we welcome Dr. Edward N. Brandt, Assistant Secretary for Health.

Dr. Brandt, we appreciate your being with us. If you will introduce the people who are with you, we would appreciate that. We note that you have submitted a statement for the record which will be made a part of the record in full, and in accordance with our procedure we would appreciate it if you would summarize that statement, leaving the maximum amount of time possible for questioning.

INTRODUCTION OF ASSOCIATES

Dr. BRANDT. Let me begin by introducing my colleagues who are with me today. To my left, Wilford Forbush, who is the Deputy Assistant Secretary for Health Operations; to my right, Jack Mahoney, who is Chief of the Budget Branch for the Public Health Service. To my far right is Ellen Wormser, Director of the Division of Health Budget Analysis in the Office of the Secretary.

I appreciate the opportunity to appear here today to discuss the budget request for the programs in the Office of the Assistant Secretary for Health. Funds are requested to support four different appropriations.

First, I would like to summarize the health services management portion of the budget.

Both the National Center for Health Services Research and the National Center for Health Statistics are truly national resources. In the National Center for Health Services Research, the highest priority in 1983 will be placed on research that is consistent with my overall emphasis on prevention and health promotion, as well as the analysis of new, controversial, or possibly cost-ineffective medical technologies.

The National Center for Health Statistics is a national resource for health data. The Census Bureau, the States, and researchers all over the world are users of this data. Our 1983 budget request maintains funding for existing surveys and proposes to expand both the National Health Interview Survey and the Hispanic Health and Nutrition Examination Survey.

One of the major themes of the Public Health Service, which you will hear reiterated today and throughout this coming week, is the commitment of this administration to prevention. Four major prevention programs—adolescent family life, smoking and health, health information and health promotion, and physical fitness and sports—operate under my direct supervision, and I am requesting additional funds for each. Indeed, for the adolescent family life program, we will be requesting a supplemental appropriation of $10.3 million for fiscal 1982 and requesting $16 million in 1983.

ADOLESCENT FAMILY LIFE

Senator SPECTER. How does that fit in, Dr. Brandt, with the general approach of the administration to budget cuts?

Dr. BRANDT. The adolescent family life program is oriented toward teenage pregnancies, with specific emphasis on prevention of teenage pregnancies, thereby, in our view, decreasing the impact on the overall Federal budget in future years. We plan to set up model demonstration programs.

Senator SPECTER. It's a costcutting increase.

Dr. BRANDT. Yes; it's a costcutting increase.

PARENTAL NOTIFICATION

Senator SPECTER. Does that program tie into the current controversy over requiring that parents of teenagers be notified before getting contraceptive devices?

Dr. BRANDT. The current controversy is over a proposed regulation that affects the family planning program in title 10, which delivers contraceptive materials, devices, and drugs not only to teenagers but to people of all ages.

The adolescent family life program is oriented more toward the prevention side than it is toward the delivery side.

Senator SPECTER. Prevention of what?

Dr. BRANDT. Prevention of teenage pregnancies.

Senator SPECTER. How does that differ, then, from the title 10 issue?

Dr. BRANDT. The basic approach of this program is to try to get the parents involved with their children in the hope of decreasing sexual activity and in the hope of getting more consistent use of contraceptives if the teenagers are sexually active. The proposed regulation will apply to any prescription contraceptives that are issued under this program.

DECREASING TEENAGE SEXUAL ACTIVITY

Senator SPECTER. What is the essential approach on trying to get decreased sexual activity?

Dr. BRANDT. Excuse me?

Senator SPECTER. How do you go about getting a decrease in sexual activity?

Dr. BRANDT. I would like to ask Mrs. Mecklenburg, who is the director of this program and the Director of the Office of Adolescent Pregnancy Programs, to address the issue in some detail.

Mrs. MECKLENBURG. Mr. Chairman, first let me add to what Dr. Brandt has said. What the adolescent family life program will be doing is not only addressing the prevention issue but also pregnancy care models for the already pregnant teen and her children. It also has a research element that covers service delivery systems, prevention, and support.

I just wanted to make that clear. The adolescent family life program is not only a primary prevention program, but it also will be developing models of pregnancy care and prevention of the second or third pregnancy. By intervening in a constructive way the program helps these young mothers finish school or get job training, as well as give birth to a healthy child, thus preventing further costs to the taxpayers and also costs in human terms by helping the individuals involved cope with the situation successfully.

To get back to the prevention issue which you asked about specifically, I would like to emphasize that this is not a direct service program. Every part of the program, including the prevention and support aspects, is concerned with demonstration, evaluation, and research.

In other words, we are not taking the place of any service delivery program, such as title 10, family planning. That is a direct service delivery program.

POSSIBLE OVERLAP WITH FAMILY PLANNING PROGRAM

Senator SPECTER. Well, without leaving my question again which you haven't gotten to yet, why the overlap, or is there none, with the title 10 program?

Mrs. MECKLENBURG. No; these programs could be seen as compatible and, in fact, complementary. In the service delivery and demonstration model program we are looking for new approaches and ways to deal with the pressures that are on our teenagers to become sexually active early.

Senator SPECTER. Before you get to the substance, why is it necessary to have two separate programs, service delivery and new approaches? Wouldn't it be more efficient to have that in one unit?

Mrs. MECKLENBURG. I suppose there could be one program, but they have been authorized as separate programs. The service delivery system has tremendous needs placed on it at this time. There are numbers of low-income women who are in need of services, and there is a real challenge to use the available funds in order to make sure the truly needy are served.

Senator SPECTER. Whatever Congress has done it can undo.

Mrs. MECKLENBURG. I'm sure that's true.

Senator SPECTER. And that's the purpose of the hearing, of course.

Mrs. MECKLENBURG. Yes.

Senator SPECTER. I just want to get this affirmed, that you think that you could have in one unit both service delivery and new approaches; there is no reason to have two units handling those two facets of the same issue.

Mrs. MECKLENBURG. Well, I can't say that it wouldn't be possible. It just happens that it was not the practice in the last administration and it is not what the authorizing committees have suggested. But I would like to think about that. One is a service delivery program and one is a demonstration model aimed at teenagers.

Because the majority of clients served in the title 10 program are adult women, and only about 34 percent are teenagers, the teenage population does not receive adequate attention. In addition, the techniques that are used to deal with teenagers are quite different from those used with the adult population.

Unfortunately the same kinds of counseling techniques are often used in both situations.

Dr. BRANDT. Mr. Chairman, I would like to put the situation in perspective.

We are proposing that the title 10 family planning program be included in the primary care block grant to be administered by the States as a part of the total range of family care programs.

The adolescent family life program is primarily a demonstration and research program which will assist in the development and evaluation of models that can be used by the States and local communities to implement programs for teenagers.

INCLUSION OF FAMILY PLANNING IN BLOCK GRANT

Senator SPECTER. Dr. Brandt, when you put it in a primary care block grant, as you articulated the concept, how can you be sure when it is in a block grant that the States will carry out that specific purpose?

We are going to come back to the sexual activity question.

Dr. BRANDT. I don't think there is any way you can guarantee that the States are going to implement the family planning program. On the other hand, I think the issue is that the States—as a matter of fact, right now in 23 States, the State health department administers the family planning program. They are the single grantee. They get the money directly from us and they administer the program. In addition, the State health agency is one of the grantees in 22 other States.

Senator SPECTER. What checks are there by your unit or any Federal agency to see to it that States do the job that this program is intended for?

Dr. BRANDT. They are required to send intended use reports so that we can see that they are in fact——

Senator SPECTER. And if they don't?

Dr. BRANDT. If they don't, they don't get the money. Under the block-grant approach, what we are attempting to do is say to the States, "You sit down and figure out what your greatest needs are and put the money there." In the primary care block, we will include a variety of primary care programs, and I am confident that family planning is going to be recognized as a need by every State. They are certainly not going to discontinue that kind of effort.

Senator SPECTER. When you say "certainly," you doubtless are right, but you might be wrong.

Dr. BRANDT. Yes, sir.

BLOCK-GRANT APPROACH TO FUNDING

Senator SPECTER. And that brings up the fundamental question of the block-grant approach. Because if some States disagree, then they have the authority to do as they choose, isn't that correct, with a block-grant approach?

Dr. BRANDT. They have the authority to spend the money where the needs are; that's correct.

Senator SPECTER. Do you think that is a wise approach?

Dr. BRANDT. Absolutely. I think that, without question, the State health department and the State agencies are much better able to determine the needs of their people than we are here. And I think they can document it, put the money where it is needed and accomplish their objectives.

Senator SPECTER. You are then willing to defer to their judgment on the need for pregnancy prevention. If they decide they don't need pregnancy prevention, then you are willing to accept that if you go to a block grant.

Dr. BRANDT. Yes, sir.

Senator SPECTER. And suppose they put into effect some policies that you disagree with. Suppose they say that before there can be a program on pregnancy prevention or pregnancy assistance or any funds for an individual—the State could say that the parents would have to know even if the woman is 22, not a teenager, above the age of majority. Would you think that such a standard would be, No. 1, appropriate and, if not, proper for a State to superimpose their will on what you and the Congress might think to the contrary?

Dr. BRANDT. Mr. Chairman, you asked me if I thought it was appropriate. I presume by that you mean would I require permission at age 22?

Senator SPECTER. Yes.

Dr. BRANDT. The answer to that is, "No."

On the other hand, I still think the State ought to be permitted that right. We certainly permit them to determine the age at which people can drive automobiles, which is certainly an important decision. We permit them to determine the age at which people can drink or at least legally buy liquor.

Senator SPECTER. How about 35?

Dr. BRANDT. Again, I think that is a State issue that I would leave up to them to decide.

Senator SPECTER. Do you think a State constitutionally could say you can't drink at 35?

Dr. BRANDT. I am not a lawyer, but I would assume they probably could not. But I think they might very well make the age limitation 21.

Senator SPECTER. They might be able to say you can't drink at 35. Some States have a hard time saying you can't drive a car at 21.

Dr. BRANDT. Yes; that's true. I grew up in a dry State.

Senator SPECTER. Which one was that?

Dr. BRANDT. Oklahoma. It was dry then but not now.

Senator SPECTER. I did, too. Kansas. There was more whisky in Russell, Kans., than in Philadelphia, Pa., when I was growing up—more bootleggers and illegal whisky.

Dr. BRANDT. But again, the law was there.

Mr. Chairman, the question that you raise is an issue that deals with the entire block-grant concept. The approach of block grants is to accomplish three things.

First, it is to increase efficiency. Funding categorical programs increases the possibility of duplication and overlap. Block-grant funding allows States to bring programs together and to deliver services, the same services, in a much more effective and efficient manner.

Senator SPECTER. Dr. Brandt, since you propose title 10 for a block, why don't you propose this for a block grant as well, like maternal and child health care?

Dr. **Brandt**. Because the adolescent family life program is a different approach. This is primarily a research and demonstration program. For the most part block grants include service delivery programs. There will be some service delivery, but the intent of this program is to set up demonstration models and evaluate them with the intention that they can then be implemented by the States and local communities. So it is a different approach.

Senator **Specter**. The maternal and child health block grant authorizes the States to use part of the block for adolescent pregnancy services, as I understand.

Dr. **Brandt**. That's correct.

Senator **Specter**. So the question arises: Why do we need a categorical program in addition?

Dr. **Brandt**. Again, I come back to the fact, that this is principally a program that is oriented toward the development, evaluation, and demonstration of new models to determine the best approaches for service delivery.

Senator **Specter**. Dr. Brandt, before you proceed with your testimony, I'd like to come back for just a moment to the testimony of Mrs.—I'm sorry, I didn't get your name.

Mrs. **Mecklenburg**. Mrs. Mecklenburg.

Senator **Specter**. How do you spell that?

Mrs. **Mecklenburg**. M-e-c-k-l-e-n-b-u-r-g.

TECHNIQUES FOR REDUCING TEENAGE SEXUAL ACTIVITY

Senator **Specter**. Mrs. Mecklenburg, the question which was referred to you which I don't think we ever got to was: What are the techniques for reducing sexual activity?

Mrs. **Mecklenburg**. We have just put a notice in the Federal Register requesting research proposals, subject to funding.

Senator **Specter**. Research proposals?

Mrs. **Mecklenburg**. Research tied to service delivery programs.

Senator **Specter**. That's a subject which almost everybody has some familiarity with.

Mrs. **Mecklenburg**. Research?

Senator **Specter**. Yes.

Mrs. **Mecklenburg**. We have been working very closely with National Institute of Child Health and Human Development because they are doing basic research in the area of adolescent pregnancy. We have a unique opportunity in this legislation to bring together service projects and research and evaluation components of those service projects.

Now, with that model in mind, let's turn to the prevention area.

We know that teenage pregnancies are increasing, especially among the very young. That is happening, even though they've had——

Senator **Specter**. How young?

Mrs. **Mecklenburg**. I can give you statistics. The number of teen pregnancies, particularly to girls under 15 has increased. In 1973 there were 24,000, in 1978 there were 26,000, and we have seen that among the very young the number of births is going up, and the number of sexually active teens also is going up.

We've had a family planning program which has obviously averted some teenage pregnancies but which has not solved the problem. And as we talk to people in the field, whether they are educators, researchers, or people in the medical community, they are aware that there is a great deal of pressure on teenagers to become sexually active. We realize that peers and parents play a particularly important part in teens decisionmaking about whether to be sexually active and whether to use contraception. However, we are not sure how these decisions are influenced. For example, there hasn't been enough investigation of sex education, or the influences from the media. Does working with parents and teenagers make a difference in postponing teenage sexual activity or help them to use contraceptives if they are sexually active?

There are a whole host of pressures and influences on teenagers which are causing them to become sexually active. However, they do not usually contracept and are becoming pregnant at an early age.

We have not adequately handled this situation, and the adolescent family life program gives us an opportunity to look at and measure some model programs and see if, in fact, they can make a difference.

These models can be used by communities along with title 10 programs, and a host of others to help them function more efficiently and more effectively.

Senator SPECTER. So the answer is, You don't know yet what the techniques will be?

Mrs. MECKLENBURG. If we did we would be able to fund the activity through a block grant and the States would know how to proceed. But the answer we get from the people in the field is that they don't know. They do know something about pregnancy care but they know more about how to work with teens after they are pregnant than how to prevent pregnancy. Of course, pregnancy care is very costly. But even though it is initially costly, proper care results in savings over the long run. What we don't know is why teens are becoming sexually active earlier in greater numbers and how we can intervene in order to encourage them to postpone that activity or to contracept successfully.

PURPOSE OF RESEARCH

Senator SPECTER. So the research you have in mind is sort of survey questioning?

Mrs. MECKLENBURG. Projects that we would likely fund and evaluate, would include parents working with teenagers in the area of sex education and research into the causes and consequences of early sexual activity. Some colleges have already begun to look at the media influence on teenagers. They would like to carry that further and target their research on how the media influences the decisionmaking process.

Senator SPECTER. Are there current studies completed on that subject?

Mrs. MECKLENBURG. No; there are none that are completed, but we've gotten thousands of letters with ideas in all of these areas. People tell us about their projects which touch on some of these issues.

I also think it will be interesting and useful to look at adolescents in general and learn from the programs in drug and alcohol abuse and smoking to see how they identify people at risk and how they work with adolescents to intervene successfully. They could have some programs that might apply to the area of teenage sexuality. If some proposals include such ideas we could try to evaluate them and see if they work. We can investigate to see if there is a way we can actually change behavior or get young people to begin to take more responsibility for their actions.

Senator SPECTER. Our Juvenile Justice Subcommittee of the Judiciary Committee has inquired into the issue of causal connection between television and violence. There are studies on that. Some of that may overlap—violence and sex.

Mrs. MECKLENBURG. It obviously could, but the area of teenage sexuality is a very distinct and specialized area. We may learn from these other studies, and investigate whether there is a connection that does apply to the sexual area.

Senator SPECTER. Dr. Brandt, let's return to your testimony before we run out of time.

Thank you very much, Mrs. Mecklenburg.

PREVENTION INITIATIVES

Dr. BRANDT. The second aspect of the prevention initiative is the Office on Smoking and Health. As you know, this past week we issued the Surgeon General's report on smoking.

The decline in the number of smokers is very encouraging. The 1983 budget request will permit us to continue our public information campaign and to maintain the Technical Information Center which furnishes scientific data both to the research and public health communities.

The budget request also includes an increase of $1.2 million for health information and health promotion which will allow us to expand our efforts to establish cooperative agreements with major national organizations such as the YMCA and the American Red Cross and others to stimulate health promotion efforts.

In addition, this request will continue our efforts to encourage Americans to participate in regular physical fitness and sports activities and will enable us to provide staff support for the President's Council on Physical Fitness and Sports.

HEALTH MAINTENANCE ORGANIZATIONS

In previous years the Federal Government provided financial support to develop the health maintenance organization concept. Now that this concept is working, our focus is to promote private industry participation in and funding for HMO's. The budget request will permit us to continue our management training and technical assistance for developing HMO's. And in addition, to support the operation of the loan fund in 1983, we are requesting $2.5 million.

PUBLIC HEALTH SERVICE MANAGEMENT

Seventeen million dollars is requested to carry out the planning, directing, and administering of the Public Health Service, which is an organization with 45,000 employees and an estimated budget of $7.8 billion in 1983.

I would like to point out that because of significant changes in Public Health Service programs we have analyzed the need for program direction and support services and have requested a reduction in 1983. By the end of 1983, with this proposed budget, we will have reduced the program direction staff by 37 percent since 1981.

To provide for expenses related to the separation of employees, $9.9 million is requested by the Public Health Service. The 1983 agency budget requests call for the elimination of 1,185 additional positions.

REQUEST FOR BLOCK GRANTS

We are also requesting funding for the preventive health and health services block and the alcohol, drug abuse, and mental health block at approximately the same level as 1982.

The block-grant concept has been accepted by the States. As a matter of fact, we now anticipate that all States will assume full responsibility for the administration of these two block grants, by the beginning of fiscal 1983.

We believe that after the transition from categorical programs to block grants in fiscal year 1982, a single Public Health Service unit for administering these two block grants will streamline procedures and simplify State and Federal contacts. For this reason, funding for two of the health block grants is requested through my office.

RETIREMENT PAY AND MEDICAL BENEFITS

Our final request is for retirement pay and medical benefits for commissioned officers. A major change in this account in 1983 is the addition of the medical and dental care costs of active duty Public Health Service officers who were formerly treated by the Public Health Service hospitals and clinics system.

Another change is that we are no longer funding the medical care for retirees and dependents of the uniformed services personnel of the Coast Guard and the National Oceanic and Atmospheric Administration.

The total request for retirement pay and medical benefits is $85.4 million.

That concludes my testimony, Mr. Chairman. I will be happy to respond to questions.

PREPARED STATEMENT

Senator SPECTER. Your prepared statement will be entered in the record at this point.

[The statement follows:]

STATEMENT OF EDWARD N. BRANDT, M.D.

I appreciate the opportunity to appear here today to discuss the budget request for the programs in the Office of the Assistant Secretary for Health. Funds are requested to support four different appropriations. The Health Services Management appropriation request of $109.6 million includes funding for a number of specific health programs and supports the overall program direction of the Public Health Service. The budget request for the Health Maintenance Organization Loan and Loan Guarantee Fund for Fiscal Year 1983 is $2.5 million. The Health Block Grant appropriation request is $515.6 million for two of the four block grants and $85.4 million is requested for Retirement Pay and Medical Benefits for Commissioned Officers. In addition, a supplemental appropriation of $10.3 million is requested for the Adolescent Family Life Program in 1982.

HEALTH SERVICES MANAGEMENT

Both the National Center for Health Services Research and the National Center for Health Statistics are truly national resources. The research and analysis produced by these Centers is essential if we are to improve our health care system and reduce its spiraling costs. Recent findings by the National Center for Health Services Research could lead to significant reductions in health care costs. For example, 16 percent of total Medicaid drug expenditures could be saved by a national capitation program for Medicaid reimbursement for drugs. Another study revealed that heart attack victims who have no complications can be discharged 10 days earlier than previously thought. This finding could save $500 million annually. We plan to continue these types of research efforts at approximately the 1982 funding level. Highest priority in 1983 will be placed on research that is consistent with my overall emphasis on prevention and health promotion as well as the analysis of new, controversial or possibly cost-ineffective medical technologies.

The National Center for Health Statistics is a national resource for health data on vital events including births, deaths, and marriages and a variety of special data such as illness and disability of the United States population, and the health effects of environmental, social and work conditions and other health hazards. The Census Bureau, the States, and researchers all over the world are users of this data. Publications of the data include the Department's annual health report to Congress, entitled *Health, United States.* Our 1983 budget request maintains funding for existing surveys and proposes to expand the National Health Interview Survey.

The requested increase will also permit expansion of the Hispanic Health and Nutrition Examination Survey to collect data for two additional Hispanic population subgroups, Puerto Rican Americans and Cuban Americans.

One of the major themes of the Public Health Service, which you will hear reiterated today and throughout the week is the commitment of this Administration to prevention. Four major prevention programs -- Adolescent Family Life, Smoking and Health, Health Information and Health Promotion and Physical Fitness and Sports -- operate under my direct supervision and I am requesting additional funds for each.

Recent data has revealed some startling trends in teenage pregnancies. There were over 560,000 births to teenagers in 1979 and the number of out-of-wedlock births to teenagers is close to a record high. The risk of complications of pregnancy and childbirth is also higher for teenagers, and the rate of maternal mortality is consistently higher for those under 20 as compared to those aged 20 to 24.

To address this special health concern, we are requesting a supplemental appropriation of $10.3 million in 1982, and $16 million in 1983. These funds will be used to develop and evaluate models of service delivery programs which could be utilized by the states and local communities. These grants would emphasize the participation of family members as an essential aspect in the comprehensive range of services to adolescents. The hope is that this approach will be a positive intervention in reversing the high incidence of pregnancy among teenagers.

The decline in the number of smokers is encouraging. The estimated percentage of adult cigarette smokers is down to 33 percent, which is the lowest rate in almost 45 years. However, 54 million Americans still smoke and certain population groups are at greater risk from smoking. We intend to target our efforts toward these groups which include pregnant women, children, adolescents and people exposed to occupational health hazards. The 1983 budget request will permit us to continue our public information campaign and to maintain the Technical Information Center which furnishes scientific data to the research and public health communities. Through these efforts we hope to continue to reduce death, disability and the health care costs associated with smoking.

The budget request includes an increase of $1.2 million for health information and health promotion to expand our efforts to establish cooperative agreements with major national organizations such as the YMCA and the American Red Cross to stimulate health promotion efforts. We will support the establishment of training networks to enable the staffs of these organizations to conduct sound health promotion programs. The National Health Information Clearinghouse, which distributed over 1.8 million items for the general public in 1981, will continue public distribution of information on a variety of health topics in 1982 and 1983.

The 1983 budget request will also continue our efforts to encourage Americans to participate in regular physical fitness and sports activities, and will enable us to provide staff support for the President's Council on Physical Fitness and Sports. Federal staff efforts have also generated more than $20 million annually in financial support from the private sector for physical fitness activities.

In previous years, the Federal government provided financial support to develop the health maintenance organization concept as a viable and cost-effective health care system. During the period of Federal grants support, a total of 304 organizations received funds to develop an HMO or to modify an existing organization to meet Federal qualification standards. Now that the concept is working, our focus is to promote private industry participation in and funding for HMOs. The budget request will permit us to continue management training and technical assistance for developing HMOs as well as qualification reviews and compliance monitoring. Fiscal Year 1983 represents the final year of new HMO loan commitments. To support the operation of the loan fund in 1983, $2.5 million is requested.

We are requesting $17 million to carry out the planning, directing, and administering of the Public Health Service, an organization which has 45,000 employees and an estimated budget of $7.8 billion in 1983. These resources encompass the programs of the five health agencies appearing before this committee which total $6.8 billion and, in addition, include activities of the Food and Drug Administration and the Indian Health Service totalling $1 billion which are funded by other appropriations subcommittees. The management staff is being reduced in line with the program reductions and changes in the Public Health Service, and by the end of 1983, this staff will have been reduced by 37 percent since 1981.

Termination Expenses

In 1983, $9.9 million is requested to provide for expenses related to the separation of employees in PHS. The 1983 budget requests call for the elimination of 1,185 positions. A reduction in the total number of positions cannot be directly translated into the number of people actually affected by the loss of a job. The Department has been successful in assisting people to find alternative employment and will continue these efforts. The majority of the positions eliminated result from the consolidation of categorical programs into block grants, completion of the closure or transfer of PHS hospitals, and program reductions in such areas as health planning and health professions education.

HEALTH BLOCK GRANTS

The 1983 budget proposes $81.6 million for the Preventive Health and Health Services Block Grant and $432 million for the Alcohol, Drug Abuse, and Mental Health Block Grant. These funding levels are approximately equal to the 1982 level. I am pleased to report that as of January 1, 1982, 48 States and five of the eligible U.S. territories have been administering the Preventive Health and Health Services Block Grant, and 49 States and five territories have assumed responsibility for the Alcohol and Drug Abuse and Mental Health Services Block Grant. Furthermore, we expect that all States will have assumed full responsibility for the administration of these grants by the beginning of Fiscal Year 1983. Because Fiscal Year 1982 marks the successful transition from categorical to block grants, fiscal 1983 funding for this appropriation is requested in my office. A single PHS unit for administering these grants will streamline procedures and simplify State/Federal contacts while assuring maximum flexibility to the States in administering these health block grants.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

This appropriation funds the retirement payments for Public Health Service Commissioned Officers, the cost of medical care for active duty and retired officers and the medical care costs of their dependents. A major change in this account in 1983 is the addition of the medical and dental care costs of active duty PHS officers who were formerly treated by the PHS Hospitals and Clinics system. Also, we are no longer funding the medical care for retirees and dependents of the uniformed services personnel of the Coast Guard and the National Oceanic and Atmospheric Administration. Beginning in 1983, the care for these beneficiaries is to be appropriated in the accounts funding those organizations.

The request of $85.4 million includes $59.9 for retirement payments, $3.4 million for survivor benefits, and $22.1 million for medical care.

I will be happy to respond to any questions you may have.

BIOGRAPHICAL SKETCH

Edward N. Brandt Jr. was sworn in May 14, 1981, as assistant secretary for health, Department of Health and Human Services. Dr Brandt was nominated by President Reagan Feb. 13, 1981, and confirmed by the Senate May 4, 1981.

Before joining HHS, Dr. Brandt, a physician, was associated with the University of Texas. Since 1977, he had been vice chancellor for health affairs for the university system, based in Austin. From 1970 to 1977, he was executive dean of the university's Medical Branch in Galveston. He had also served since 1970 as professor in the university's departments of preventive medicine and family medicine. From 1962 to 1970 Dr. Brandt was at the University of Oklahoma Medical Center, first as director of the Medical Research Computer Center and later as associate dean.

As assistant secretary for health. Dr. Brandt directs the activities of the Public Health Service, which includes the Health Services Administration; the Alcohol, Drug Abuse and Mental Health Administration; the Centers for Disease Control; the Food and Drug Administration; the Health Resources Administration; and the National Institutes of Health.

Dr. Brandt provides policy guidance for other HHS health programs including the Health Care Financing Administration, which administers Medicare and Medicaid. He also maintains relationships with other governmental and private agencies concerned with health. He advises and assists the Secretary on health policy and on all health-related activities of the department.

Dr. Brandt was born July 3, 1933, in Oklahoma City, Okla. He received his B.S. degree in mathematics from the University of Oklahoma in 1954 and an M.S. degree in mathematics from Oklahoma State University in 1955. He received his M.D. in 1960 from the University of Oklahoma Medical Center and a Ph.D. in biostatistics from the same university in 1963. Dr.Brandt served his internship at the Veterans Administration Hospital in Oklahoma City and was an internal medicine resident at the University of Oklahoma Medical Center.

Dr. Brandt has been active in various committees of the American Medical Association, Texas Medical Association and the American Association of Medical Colleges. At the time of his confirmation as assistant secretary for health, he was serving as chairman of the AMA's section on medical schools. He is also a member of the American Academy of Family Physicians' Commission on Legislation and Governmental Affairs. He has served on many boards, committees and foundations and holds memberships in a number of honorary and professional societies.

Dr. Brandt has published extensively and has made significant contributions to the professional literature throughout the entire range of health and statistical issues.

Dr. Brandt and his wife, the former Patricia Lawson, have three sons: Patrick James, Edward N. III and Rex Carlin.

SURGEON GENERAL

Senator SPECTER. Dr. Brandt, how does your Department tie into the Surgeon General's office? Does he have Assistant Secretary status as well?

Dr. BRANDT. No, sir, the Surgeon General reports to me.

Senator SPECTER. He reports to you.

Dr. BRANDT. Yes, sir.

Senator SPECTER. Is there anybody in between the Surgeon General and you in the chain of command?

Dr. BRANDT. No, sir.

INCREASING ATHLETIC ACTIVITY

Senator SPECTER. What are the plans which you have for increasing athletic activity? If you can spell that out just a little bit more, I would appreciate it.

Dr. BRANDT. Let me introduce to you Mr. Casey Conrad who is the chief staff person for the President's Council on Physical Fitness and Sports. He can address that issue.

Mr. CONRAD. Mr. Chairman, the President's Commission on Olympic Sports studied and recommended, and Congress passed, the Amateur Athletic Act of 1978, and in the Commission's report it recommended that the President's Council at a sub-Cabinet level have the responsibility of implementing that program as related to the Federal Government.

This is the reorganization of the amateur sports program in the United States.

This has placed a great deal of importance on what is called the national sports governing bodies. And the National Track and Field Association, which is now called the U.S. Congress for Athletics, has really taken the place of the AAU.

In the reorganization of this whole program——

Senator SPECTER. Excuse me. Are there going to be increases in Federal expenditures to promote this objective?

Mr. CONRAD. I hope not, sir. We don't see the Federal Government being a sports bureaucracy. As a matter of fact, the President's Council took the leadership, during the hearings of the President's Commission on Olympic Sports, to stay away from that.

For example, in Canada, our counterpart there has a budget of $40 million, and it looked like the recommendations were going in that direction, but through considerable lobbying and the influence of the members of the President's Council, who are 15 Presidential appointees, that was changed.

Senator SPECTER. Line 4410, physical fitness and sports, is up.

Dr. BRANDT. The increase is not for the activity that Mr. Conrad was addressing which is the national amateur sports organization. Rather, our budget increase is aimed at an expansion of the total physical fitness program in the schools and communities.

Senator SPECTER. I'd like to hear the completion of your program, and then I'd like to come back to what is contemplated as the expansion version.

Mr. CONRAD. I just wanted to mention that I think at times the President's Council on Physical Fitness and Sports is looked upon as promotional and related only to exercise. Actually, under our Executive order, the Council has responsibility in four areas.

One is exercise or physical fitness, and with adults we have done a pretty good job. We still have a long way to go because we are losing ground in school programs.

Physical education is the second area.

The third area is the area of sports medicine, which is a $2 billion emergent industry today.

Senator SPECTER. Sports medicine?

Mr. CONRAD. Sports medicine.

Senator SPECTER. What does that mean?

Mr. CONRAD. Sports medicine is the medical application of the knowledge of the profession to the prevention and correction of sports injuries.

I could best illustrate it by saying the pediatrician, or the general practitioner, I should say, may not have had many sports injuries in his office before, but now suddenly he finds somewhere between four to six or eight a day. Suddenly he wants to know, "What should I do about those bad knees, about the tennis elbows?" or about some of the other problems that are largely orthopedic problems.

Senator SPECTER. What accounts for that? Are people playing a lot more tennis, squash, and that sort of thing?

Mr. CONRAD. Yes, sir. There's a veritable sports and fitness boom in this country, and there's nothing like it in the rest of the world.

INCREASE FOR PHYSICAL FITNESS PROGRAM

Senator SPECTER. Dr. Brandt, going back to line 4410, I wonder if you can amplify for me what is the increase in physical fitness and sports, that category.

Dr. BRANDT. Of the $140,000 increase, $65,000 represents mandatory increases that are associated with continued operation of the program; $75,000 will support strengthening and expanding of school and work-based physical education programs, and will provide for increased activities in sports medicine.

SMOKING AND HEALTH INCREASE

Senator SPECTER. How about the smoking and health line?

I see you're up to $194,000. You can probably take a cut on that after Dr. Koop did such a superb job on the national media.

Dr. BRANDT. I would say, sir, that the first Surgeon General that addressed the issue of smoking was Dr. Leroy Burney in 1957, 25 years ago. The first Surgeon General's report was issued in 1964, 18 years ago, yet we still have 52 million people who smoke. It's the leading cause of preventable illness in this country. There is still a lot of work that needs to be done.

Of the increase requested, $52,000 is for mandatory costs and the balance of $142,000 will allow us to develop further our public and technical information activities.

BLOCK-GRANT ADMINISTRATION IN OASH

Senator SPECTER. For the fiscal year 1983, the administration proposes to place the administrative responsibility for the health block grants, preventive, alcohol, drug abuse, and mental health in the Office of the Assistant Secretary for Health.

The Centers for Disease Control now administer the preventive block, and the Alcohol, Drug Abuse, and Mental Health Administration administers the block relating to its area.

The first question is: What is the reason for putting the administration of these blocks in OASH? Does OASH have the staff to run them?

Dr. BRANDT. Yes, sir. The concept behind the block grants is to allow the first year to be a transition year during which time the agencies previously administering the categorical programs were to work with the States to phase out the categorical programs and to also assist the States in implementing the block grants.

Once block grants are fully developed and operational in the States, it then becomes a more routine management activity which can be streamlined and centralized. Technical assistance will still be provided by the staff requested for block-grant administration.

Senator SPECTER. Why were these two particular block grants proposed for inclusion in OASH while the maternal and child health block and primary care block were not?

Dr. BRANDT. The main reason is that the two block grants proposed for inclusion in OASH are in a transition year in 1982. They will be fully operational by 1983. On the other hand, fiscal year 1983 will be the transition year for maternal and child health care and the primary care block grants. In addition if changes we have proposed in the maternal and child health block grant are adopted by the Congress, we will be starting a new program in 1983 which involves phasing out categorical programs requiring people from the agencies to be involved.

Senator SPECTER. In centralizing the administration of these block grants in OASH, it would appear the expertise and knowledge of the CDC and ADAMHA staffs would be lost in the process. What steps do you propose to take to make certain the staff expertise follows the blocks if they are shifted?

Dr. BRANDT. It is our intention to include both ADAMHA and CDC personnel in the administration of block grants in OASH so they can provide technical assistance on a continuing basis.

In 1983 the block grants will require overall management and that assistance will be available through my office.

Technical assistance is currently provided in several areas and that assistance will continue.

Senator SPECTER. Dr. Brandt, complaints have been received, according to the information provided by the staff, that overhead expenditures by State governments are cutting into services. What are you doing, if anything, to assure that administrative expenses in States are held to the minimum?

Dr. BRANDT. States are restricted to not more than 10 percent of the block-grant allocation for administrative costs for the alcohol, drug abuse, and mental health block grant and the preventive health block grant.

HEALTH SERVICES RESEARCH ACCOMPLISHMENTS

Senator SPECTER. Moving now to the National Center for Health Services Research, the purposes of the National Center are to produce knowledge about health services to related fields which will assist in improving the delivery of health services and potentially reduce costs.

Can you briefly summarize some of the significant accomplishments during the past year?

Dr. BRANDT. Yes; let me call on Dr. Harold Margulies.

Dr. MARGULIES. The National Center for Health Services Research has a series of activities which have been ongoing for quite some time. During the past year they have addressed a range of issues which have to do with costs of medical care, with the effectiveness of various kinds of health insurance. They have addressed technology assessment, and they have a long series of reports which have been widely distributed which I think have had a significant influence.

Senator SPECTER. What is the central thrust of what you're doing on private-use hospital costs, for example?

Dr. MARGULIES. You're getting a little detailed. I'd like to pass that on to Dr. Goldstone.

Senator SPECTER. What is your name?

Dr. GOLDSTONE. Donald Goldstone.

Senator SPECTER. Do you have an assistant here, Dr. Goldstone?

Dr. GOLDSTONE. No, sir.

Senator SPECTER. There's a four-tier group before this subcommittee. You can delegate once more.

Dr. GOLDSTONE. Let me go back to the earlier question that you asked, and that was a question that had to do with what kind of research had been done that might be useful.

Senator SPECTER. How many questions are you going to go back to? If you have that many answers, we are going to have some problems.

Dr. GOLDSTONE. I have a list in front of me, which I could submit for the record, but some of the findings over about the last 1½ years have been significant. Two areas studied were homemaker and day care services for the elderly. We did an experiment to see what kinds of impacts they would have. That research did not demonstrate that there was any significant impact on the health of the recipients of those services.

Senator SPECTER. What question are we relating to?

Dr. GOLDSTONE. You asked a moment ago what kind of research findings had occurred in the past from the National Center for Health Services Research that might be of some use——

Senator SPECTER. I didn't ask for research items. I asked for significant accomplishments during the past year.

Dr. GOLDSTONE. Well, we are a center that does research.

RESEARCH ON HOSPITAL COSTS

Senator SPECTER. OK; fine. All right.

How would you relate the accomplishments of the past year to the central question of hospital costs which is on the minds of so many people at the present time?

Dr. GOLDSTONE. I don't think I understand the question. That is, what findings might be relevant to——

Senator SPECTER. Well, we're talking about the costs of the delivery of health services.

Dr. GOLDSTONE. Yes, sir.

Senator SPECTER. And if there is one cost which is probably central to health costs in this country today, it is hospital health costs.

Dr. GOLDSTONE. Yes, sir.

Senator SPECTER. And in evaluating what the National Center for Health Services has done, I would be interested to know what you have done on the issue of hospital health costs.

Dr. GOLDSTONE. Well, one of the principal thrusts of the Center at this moment in time is trying to analyze what new technologies introduced into the hospital settings have done to influence both the costs and the quality of care. We are looking at such examples as knee and hip replacements. These kinds of technologies represent tremendous increases in the costs of care being provided patients. And what we wish to know is what those costs are, how they might be modified, and what the benefits of that kind of technology are.

Senator SPECTER. Do you tackle the broader question as to why costs—what is it—$200 a day to be in the hospital? What does it cost to be in the hospital a day? I'm happy to say I don't know.

Dr. BRANDT. The average daily cost of a hospital stay would be about $300.

Senator SPECTER. Secretary Schweiker was with the Pennsylvania delegation yesterday for lunch and discussion of departmental issues just for old time's sake and commented that there was a program to be implemented that charged $1 a day to people for staying in the hospital.

And Congressman Ritter said, "How can you have any effect on what people are going to do for $1 a day?"

Secretary Schweiker replied that there were findings that when people were discharged on Friday, they didn't want to leave on Friday; they wanted to stay the weekend. And they were being sentenced not to stay for $1 a day.

Does any of the research bear on that monumental question?

Dr. GOLDSTONE. That particular question I cannot respond to. However, we did a study which looked at a set of patients that had very common characteristics, who all had had minor heart attacks and who were admitted to hospitals. And as near as following those patients could demonstrate—the usual length of time for keeping patients with those characteristics in the hospital across the country runs between 10 and 14 days. Our research demonstrated that you could discharge those particular patients earlier without any evidence of harm to them.

DIRECT SAVINGS RESULTING FROM RESEARCH

Senator SPECTER. Could you give us some examples of any direct savings which accrue to the States because of programs which they have implemented from recommendations of the NCHSR?

Dr. BRANDT. I don't think that estimate is available because much of the research, as it is implemented, is incorporated with other activities. It is difficult to attribute direct cost savings to a specific research effort.

We can give you some examples and will provide that information for the record.

[The information follows:]

RECOMMENDATIONS IMPLEMENTED BY STATES

Computer system.—The computer stored ambulatory record—COSTAR—system, developed under a National Center for Health Services Research grant is now being marketed to health care providers by over 20 commercial vendors of computerized services. Recent experience in publicly funded county health departments indicate that they have been able to maintain access and quality care services for people without payment means by increasing appropriate collections from individuals who can pay for services directly or through insurance. These benefits have been achieved because of COSTAR's built-in directory of private insurance carriers and its capability to generate immediate billing forms and eligibility checks. The result is improved cash flow due to a reduced billing cycle, a more systematic questioning of the patient to identify privately owned insurance, and reduced lost charges for services provided but not billed. The Department of Health Services, County of San Diego, has led in the adoption of this technology as a means to reduce the impact of decreasing Federal and State matching funds and the increasing demand for county-provided primary care services. Preliminary data from the initial nine clinics using COSTAR in San Diego County show general revenue increases of approximately 30 percent. In addition, in one group of five clinics sharing a central computer, the number of lost charges—frequent in the billing of blood chemistries—was reduced by 8 percent.

Stimulated by the magnitude of these benefits, over 10 other California county health departments are now in various stages of implementing COSTAR systems that replicate or expand upon the San Diego experience. The expanded applications will take advantage of COSTAR's powerful medical record storage and retrieval capability to integrate primary care services with other county-provided services in the areas of tuberculosis, venereal diseases, immunization planning, and vital statistics. This positive fiscal impact of COSTAR systems in California is now drawing the attention of health care administrators and providers in many other States.

DRUG SUBSTITUTION SAVINGS

Center research has investigated the potential of cost savings to the American consumer-taxpayer of drug substitution laws. Based upon NCHSR studies in Michigan, Wisconsin, Rhode Island, and Vermont, Dr. Ted Goldberg from Wayne State University, and his colleagues estimate that the potential for savings is nearly $3 billion. However, pharmacists actually substitute in less than 6 percent of prescriptions. Dr. Goldberg and colleagues have reported their findings before State legislatures in Indiana, Hawaii, Michigan, and Kentucky. Their testimony included strategies for optimal drug substitution laws. Their findings were presented before the U.S. House of Representatives Committee on Interstate and Foreign Commerce.

DRUG REIMBURSEMENT BY CAPITATION

The Center supported an experiment whereby pharmacists were reimbursed on a capitation basis rather than a traditional fee-for-service system. The change in the method of reimbursing pharmacists led to a sixfold increase in the rate of generic drug substitution. If the findings from this study hold up in an extended study, the total savings to the medicaid program, if all States adopted capitation payment to pharmacists, would be 16 percent of total drug costs, or approximately $210 million.

NURSING HOME STUDY

A very serious institutional care problem is that of patients in hospitals awaiting entry to nursing homes. In California alone, it has been estimated that more than $3 million each year is expended by the MediCal system to pay for keeping severely dependent individuals in hospitals because nursing homes, faced with excess demand for their services, decline to admit them. The figure does not include the additional expenditures for those patients covered by medicare. The NCHSR in cooperation with the State of California is currently conducting a study that approaches this problem by encouraging nursing homes to admit more dependent patients and to take increased responsibility for these patients by providing care, discharge planning, and postdischarge followup in the community. If successful, the project may reduce hospital backup making nursing homes more willing to accept the type of patient now being avoided: Those whose conditions are extremely costly to treat. It also may improve patient outcomes and discharge rates. Preliminary findings from the study, which is taking place in 36 San Diego County proprietary nursing homes will be available late this year.

HOSPITAL COSTS

Senator SPECTER. I think that would be useful, if we could have something concrete.

I think it also would be useful if you could provide us with what you are doing on the overall issue of hospital costs, and specifically if you could supplement what Secretary Schweiker commented about, the dollar a day, what authentication there is for that, and what experience you have on this weekend stay-over issue. It's hard to see $1 a day being too determinative.

Dr. BRANDT. Secretary Schweiker was talking about medicaid and medicare patients where $1 a day is a sizable amount of money.

Senator SPECTER. But if they leave the hospital, their own food costs per day would be in excess of $1.

Dr. BRANDT. Yes.

Ms. WORMSER. Senator Specter, I think it's useful to point out there's another research activity which goes on in the Health Care Financing Administration which is targeted more at the questions concerning hospital costs that you were raising. They, for example, were the ones that funded a whole series of prospective reimbursement experiments in States designed to show how this approach to reimbursement could help reduce hospital costs, and it is in HCFA where the research in this area has been targeted.

Senator SPECTER. Dr. Brandt, we will be submitting a fair number of questions for the record which the staff has prepared.

One of the great difficulties of these Senate hearings is that Chairman Schmitt could not be here today because of other commitments, and after this was scheduled they have scheduled a Judiciary Committee meeting with the chairman of the U.S. Civil Rights Commission, which is on for 11 o'clock, which I must attend.

Dr. BRANDT. Certainly.

Senator SPECTER. So these questions will be developed on the record, and if you will submit answers to them we would appreciate it.

And for the time remaining, I would like to ask some questions which the staff has indicated are really in the center philosophically of what they are interested in on the child care, pregnancy prevention, block-grant concept.

Dr. BRANDT. All right.

RÉSUMÉ OF THE ASSISTANT SECRETARY FOR HEALTH

Senator SPECTER. But before going into that, I notice from your résumé you are a University of Oklahoma graduate.

Dr. BRANDT. Yes, sir.

Senator SPECTER. I would like to know if any of the programs here related to the work which Bud Wilkinson used to do for the President years ago.

Dr. BRANDT. Yes; he was the chairman of the President's Council on Physical Fitness during the Kennedy administration in the early years of the Council.

Senator SPECTER. I notice you were a late arrival at the University of Oklahoma. I started there in 1947, the year in which Bud Wilkinson was the coach. But I only had the benefit of staying there 1 year. I was not a football player. [Laughter.]

Dr. BRANDT. Neither was I, but during my entire tenure there, they only lost two football games, and those were great tragedies, as you can imagine.

Senator SPECTER. Notre Dame?

Dr. BRANDT. No, sir, to the Univesity of Texas and Texas A&M. [Laughter.]

Senator SPECTER. Well, those are tragedies. [Laughter.]

Dr. BRANDT. However, my most recent activity has been at the University of Texas.

Senator SPECTER. You have more losses to show to Oklahoma as a Texan than to Texas as an Oklahoman? [Laughter.]

Dr. BRANDT. No, sir.

Senator SPECTER. Who do you root for, now that you're a Washingtonian?

Dr. BRANDT. Does that have to be on the record, sir?

Senator SPECTER. Before you answer those questions, I think I would administer the oath which we dispensed with in view of your lofty position.

Dr. BRANDT. You might be interested when I went to the University of Texas that the head football coach was Darrell Royal.

Senator SPECTER. He was a halfback in 1947.

Dr. BRANDT. Yes, sir. But I root for the University of Texas.

Senator SPECTER. Going back to lesser subjects, on block grant versus categorical grant, which I suppose next to college football is as important a subject as there is in this country today on a very serious level.

Dr. BRANDT. Yes, sir.

CONCERN ABOUT BLOCK-GRANT FUNDING

Senator SPECTER. There are many of us who have very grave concerns about the whole block-grant concept and on the central issue of how national goals have been defined and put into the law. With the block-grant approach, what assurances do we have that the States will carry out these important purposes, such as pregnancy prevention?

Dr. BRANDT. I would like to make several points on this issue. The first point is that, in general, the States already administer many of those programs including the categorical programs. For example, we have established immunization goals, the money goes to the States, and they do the work. Basically all we do is monitor the activity.

The point is, that even if programs are categorical, we are still going to be dealing largely with the same organizations.

However, our purpose here is to set up criteria and determine needs and the future direction of certain programs.

We have now learned that even that is much more difficult to do from Washington than it is at the State level.

Senator SPECTER. Are you saying essentially that you have a lot of confidence in this field, in health care, and the States have good instincts and good judgments and will follow these matters through?

Dr. BRANDT. Yes, sir.

Senator SPECTER. No exceptions at all that you have found such as State administrations that are so bad that you have to have somebody tell them something?

Dr. BRANDT. I would say that the percentage is equivalent to that of Federal administrators.

Senator SPECTER. That bad? [Laughter.]

Dr. BRANDT. I think there probably are going to be some States that will have difficulty with block grants. There could be areas where State legislatures may intervene, but I think those instances will be relatively rare.

Most of the people in the State health departments and local and county health departments are experienced, committed people, and they know what the national goals are. Indeed, they assist in setting the national goals. They are the ones that bring issues to our attention.

Senator SPECTER. Do you think there is any difference in other fields? For example, in education can we have the same confidence in all the States in education, given the history of this country with segregation, for example?

Dr. BRANDT. That is not my area of expertise, but I think we are at the point now where we can have that kind of confidence in the States.

Senator SPECTER. What about the Mississippi case? You were in high school at the time.

Dr. BRANDT. Oh, yes, I remember.

Senator SPECTER. Sought admission to the University of Oklahoma Law School.

Dr. BRANDT. Oh, yes.

Senator SPECTER. You think we're past that?

Dr. BRANDT. I think we are past that; yes. I think the United States has changed a lot in the last 30 years. The argument may be made that State health departments are unable to carry out these duties. In my opinion, that argument is made by people who have not looked at State health departments recently.

Senator SPECTER. Have you followed the controversy in the Oklahoma juvenile institutions?

Dr. BRANDT. Yes, sir.

Senator SPECTER. Would you have the same confidence in the field of juvenile institutions?

Dr. BRANDT. I think that is clearly a problem. I don't question that there are complications that arise in situations like that. But I would suggest to you, sir, that there have been significant problems in Federal programs as well. As a matter of fact, there are problems in our own programs that are not as devastating as that one, but are still significant.

Senator SPECTER. We are out of time, but I want to touch one other subject before I adjourn this hearing.

Dr. BRANDT. Yes, sir.

PARENTAL NOTIFICATION FOR TEENAGE BIRTH CONTROL

Senator SPECTER. That is the subject of notifying parents on the birth control issue.

Dr. BRANDT. Yes, sir.

Senator SPECTER. The central question is: If you take a 20-year-old child, say, in the upper extreme, almost at the age of majority, and say that the parents have to be notified, is there a significant risk that the child will simply not take advantage of a program if a parent has to be notified and pregnancy will result?

Dr. BRANDT. At age 20?

Senator SPECTER. Well, the age probably is not so important. Perhaps it would be more relevant at a younger age. But is there not a great risk—and I don't know the answer to this question. I don't have a suggestion myself. I think there are very strong competing values that parents ought to know what their teenage children are doing, especially their younger ones, so they can have some influence on them. The other side of this is the teenager will say, "Well, I'm not going to let my folks know, and they won't be informed and I will become pregnant."

So we are cutting off our nose to spite our face, as the expression goes.

Dr. BRANDT. There are several issues. First, the parents are, in fact, responsible for those children.

The second issue is to differentiate those contraceptives that carry a significant health risk, such as birth control pills and the IUD. For example, the annual death rate among teenage girls who smoke and who take the pill is 2 per 100,000. When you consider the number of teenage girls, that is not an insignificant risk.

Furthermore, that risk increases with age. A recent article in the New England Journal shows the risk of hemorrhagic stroke increases dramatically after using birth control pills for 5 years. If a 13-year-old girl begins taking birth control pills, by the time she is 23 years old she has taken them for 10 years. That risk may now become significant, which brings up the question of parents being involved in dealing with that child to inform them of the consequences of such activity——

Senator SPECTER. But someone else could advise the child. A doctor could.

Dr. BRANDT. Yes.

Senator SPECTER. The doctor is not going to be inhibiting. If you put the parental requirement in, that is going to be an inhibiting factor.

Dr. BRANDT. The question still remains as to who is ultimately responsible for taking care of that person when those events occur. That, I think, is really the issue and the problem.

The other aspect is that some parents are going to ignore the issue and not get involved. However, they are still ultimately responsible. If, in the judgment of the counselor, there is concern that parents may inflict physical harm upon the child, they would not be required to report it.

I'd agree with you that it is a difficult issue, and there are competing values.

Senator SPECTER. Where do you come out on it?

Dr. BRANDT. I believe that the parents should be notified if the child is on a prescription drug.

Senator SPECTER. What age cutoff?

Dr. BRANDT. Seventeen.

SUBMITTED QUESTIONS

Senator SPECTER. Thank you, Dr. Brandt, and thank you, ladies and gentlemen of your staff for coming here, and I thank the staff of the subcommittee for its usual very good job. I have some questions for the record.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

PHYSICAL FITNESS AND SPORTS

Question: What new initiatives does the program anticipate in fiscal 1983?

Answer: In Fiscal 1983, through greater involvement with the private sector the staff of the President's Council on Physical Fitness and Sports (PCPFS) will increase considerably the number of projects supported by business and industry.

The staff will conduct a personal interview research survey of adults aged 22 years and over. The survey will parallel a similar national adult physical fitness survey conducted in 1972 and is scheduled to be conducted between September 15 and October 6 and between November 14 and December 10. Prior to actual field work, five forms of the questionnaire will be pre-tested among respondents. The focus of attention in the report will be related to present weight to weight at 21; sports competition when in school; physical education participation in school; attitude toward physical education; present adult participation in physical fitness activities and sources of physical fitness information. The 1972 survey provides a data base through which to compare the various categories ten years later, and will provide a means of determining the current state of physical fitness and sports and the gains or losses in various aspects of the national program during the last ten years.

Question: What would be eliminated if the budget were "held steady" with last year's budget?

Answer: Of the $140,000 proposed increase in funding for FY 1983, $65,000 are for mandatories. If the FY 1983 budget were held steady, the national adult physical fitness survey would be eliminated as well as funds in support of four staff positions which were not fully supported in Fiscal Year 1982. The elimination of the staff positions would decrease the amount of funding by the private sector in support of national projects. The program has no loans, grants or regulations. As a catalyst, it implements the ten point national program of physical fitness, amateur sports, sports medicine and physical education largely through the support of other public authorities and the private sector. In the last decade, private funds for projects have been available to the extent that the staff can develop, market and supervise projects cosponsored by the private sector. Most of the budget goes for staff salaries, consultant/clinician fees and travel. A staff cut of four positions would result in a loss of approximately 8-10 million dollars in outside support.

Question: What efforts of the program during the last year have led to the development of business or corporation-sponsored physical fitness programs that have increased the health and productivity of employees?

Answer: The PCPFS is the nation's prime mover in fitness programs for the workforce at the workplace. The Council and the American Association of Fitness Directors in Business and Industry conducted a national, two regional and a number of local business and industry clinics to stimulate the growth of corporate fitness programs. An example of a major emphasis regionally is the Health and Fitness Symposium for Business Leaders which will be held April 2, 1982 at Hershey, PA in cooperation with the Governors' Councils on Physical Fitness and Sports in Delaware, Maryland, New Jersey, Pennsylvania and underwritten by Universal, Inc. Several research projects have shown that the health and productivity of employees has improved through corporation sponsored physical fitness programs.

Question: What activities have been undertaken to increase financial support from the private sector for projects proposed and promoted by the Office?

Answer: Most of the activities undertaken are cosponsored and underwritten by the private sector. Among the private corporations which have supported projects during the past several years are: ARCO, Phillips, Charter Company, Travelers, Allstate, Penn Mutual Life, Connecticut Mutual Life, Prudential, major television and radio networks (NBC, CBS, ABC), Seven Up, Coca Cola, Post Cereals and Sanka Brand (General Foods), Campbell Soup, Nissen/Universal, Blue Cross/Blue Shield, Hershey Foods, Xerox, Walt Disney Productions, California Raisin Advisory Board.

The Second White House Symposium on Physical Fitness and Sports Medicine was underwritten by Union Mutual, Mobil and McNeil Pharmaceutical. The National Conference on Fitness and Aging was underwritten by General Foods.

Question: What outreach efforts have been made by the Office during the last year to involve low income and rural populations in these programs?

Answer: Youth Fitness Forums were conducted by the staff in twenty-two large urban cities across the nation through the cosponsorship of Post Cereals, General Foods. The clinics for volunteers and professionals demonstrated latest physical conditioning, safety and coaching techniques. Over 9,300 coaches and community leaders were involved in the programs. The majority of the youth and coaches represented low income areas.

Question: Will particular groups be targeted for inclusion in the program which perhaps were not involved in the past?

Answer: Yes. The PCPFS and the U.S. Olympic Committee (USOC) are initiating the State Games project. This amateur sports development program is being coordinated with the National Association of Governors' Councils on Physical Fitness and Sports, the National Recreation and Parks Association, the National Sports Governing Bodies and the Amateur Athletic Union (AAU). The project is characterized by grass roots participation for all ages and the handicapped.

ADOLESCENT FAMILY LIFE

Question: In reviewing the list of services provided by the program, if family planning services are not offered to non-pregnant minors, what services will bring them to the Centers? Nutrition counseling? Consumer Education?

Answer: Based on the experience of the projects funded under the Adolescent Health Program, the Adolescent Family Life demonstration projects will not have difficulty in attracting a wide variety of teen clients. Because these projects are multi-disciplinary in nature, they can offer instruction and counseling in a number of areas that are of special interest to pregnant and non-pregnant teens--for example, career counseling, job preparation, preparation for parenthood and educational services relating to family life.

Question: To what extent would this program focus on male sexual activity?

Answer: There is widespread recognition of the fact that programs providing services to pregnant teenagers and sexually active/inactive nonpregnant adolescents have not given adequate attention to male involvement. The Adolescent Family Life program recognizes the importance of the roles of both males and females in the areas of contraceptive use, and parenting and will involve males in these programs whenever possible.

Question: In view of efforts to shift the responsibility for social programs to the States, why not carry out this activity through the block grant approach? Or do you believe it can only be carried out effectively from the Federal level?

Answer: The purpose of this activity is to conduct research, demonstration, and evaluation services projects so that model service delivery programs, in both the prevention and pregnancy care areas, can be identified for use by States and local communities. This type of activity can be carried on in a systematic and efficient way only at the centralized Federal level.

Question: Would you favor continuing to carry out this program under a block grant?

Answer: No. The States can make better use of block grant funds to provide teen pregnancy services, especially if they are informed about the more effective service delivery approaches by research and evaluation conducted at the Federal level. The two levels of government will be performing very different, but complementary functions, as they seek solutions to the problem of teenage pregnancy.

Question: The Adolescent Family Life law outlines some "necessary services" which may be provided by grantees, but it is not clear as to whether "family planning services" may be offered to non-pregnant adolescents. Can you elaborate?

Answer: Section 2004 of the Adolescent Family Life law spells out conditions under which Title XX funds may be used to provide family planning services (beyond counseling and referral) to non-pregnant adolescents. Our understanding of the intent of congress in this matter derives from the legislation that states;

> "No funds provided for a demonstration project for services.... may be used for the provision of family planning services (other than counseling and referral services) to adolescents

unless appropriate family planning services are not otherwise available in the community."

Question: What is your comment to the concern which has been expressed that, while Congress called for "family involvement" in such matters, "parental consent," as called for in this law, goes beyond Congressional intent?

Answer: I do not believe that "parental consent" goes beyond Congressional intention. The legislative intent of the Adolescent Family Life Act is quite clear regarding this matter. It specifically mandates that the applicant for funding will notify the parents or guardians of any unemancipated minor requesting services from funded project except in those cases specifically cited in the legislation, for example, if notification would result in physical injury to the minor or in cases when the minor is a victim of incest involving a parent.

Question: While the law contains a formula with regard to the portion of funds which may be used for research, concern has been expressed that monies may be used for a preponderance of research staff to the detriment of services staff. What assurances do we have that this would not occur?

Answer: In providing a formula with regard to the portion of funds which may be used for research and services, Congress gave clear guidance that it wished to see a balanced approach that would not be detrimental to services delivery. The legislation requires that at least two-thirds of the program funds must be for service demonstrations, and of that amount not more than one-third will be for prevention demonstrations with the remaining funds for care services. Research activities may not exceed one-third of the appropriated funds. The Department fully agrees with this approach and will closely follow Congressional intent as we implement this program.

Program Direction and Support

Question: Can you explain the need for the level of funding, in view of diminished responsibilities as a result of the enactment of block grants and the decreased activities with respect to Public Health Service Hospitals?

Answer: The Program Direction and Support Services activity has been reduced in line with the program reductions and changes in the Public Health Service (PHS) and by the end of FY 1983 this staff will have been reduced by 37% since 1981. On a comparable basis the funding level in 1981 was $24,836,000 and 504 positions and in FY 1983 the proposed funding level is $17,037,000 and 318 positions which is a reduction of $7.8 million and 186 positions. These reductions were made in recognition of diminishing management and direction responsibilities resulting from the enactment of block grants and closure of the Public Health Service Hospitals.

It is important to point out that in addition to the five agencies of PHS which appear before the Labor/Health and Human Services/Education Subcommittee, there are two major activities of PHS--the Food and Drug Administration and the Indian Health Service --which require the oversight and coordination of the Program Direction and Support Services activity.

The resources of PHS total 45,000 employees and a requested FY 1983 budget of $7.8 billion. This level of effort reflects a significant responsibility in terms of assistance and central management responsibility to assure a coordinated health strategy among the health agencies in accordance with policies and priorities.

Termination Expenses

Question: The costs associated with the termination or reduction of Public Health Service programs are funded through the Public Health Service Termination Expenses account.

The committee appropriated a little over $40 million for termination expenses during the last fiscal year. It appears that some $10 million still remains in the account. Another $10 million is being requested for use during fiscal year 1983. Please explain briefly the disbursement of the $30 million from the amount appropriated last year.

Answer: It is estimated that most of the $39.1 million will be obligated during FY 1982. During 1982, a total of $29.8 million is required for support of restored positions in the Centers for Disease Control, the Health Services Administration and the Health Resources Administration. Funding of these positions from the OASH appropriation is authorized by House and Senate Committee on Appropriations reports and is directed by House and Senate explanations on the Continuing Resolution. Continued support of these positions is required to manage block and categorical grant programs which under Congressional action are structured differently than under the President's budget request. The remaining $10.3 million is required to cover costs associated with the termination or reduction of the various programs of the Public Health Service during 1982.

Question: What action will be taken with respect to the $10 million remaining in the account from last year?

Answer: This amount will be used for costs associated with the termination and reduction of PHS programs in 1982 and will provide for unfunded salary costs for eliminated positions which were occupied during a part of FY 1982, lump sum leave payments, severance pay, residual overhead expenses, and unemployment compensation increases.

Question: How did you arrive at the estimate of $10 million needed for fiscal year 1983?

Answer: The estimate of $10 million for 1983 is based on a planned reduction of 1,185 positions and separation of 828 employees. These reductions result from the elimination of categorical grant programs in favor of block grants and reductions in health planning, health professionals, and health services research. This amount includes funds for severance pay, lump sum leave payments, certain overhead and salary expenses related to the eliminated positions, and increased payments for unemployment compensation.

RETIREMENT PAY AND MEDICAL PAYMENTS FOR COMMISSIONED OFFICERS

Question: In the past we have appropriated "such amounts as may be required during the current fiscal year." It now appears that you are proposing a definite appropriation for this account to include a contingency fund of six and a half million dollars to cover "unanticipated requirements." Please explain.

Answer: This year we are requesting a definite amount for this account. This is consistent with government-wide efforts to reduce the number of indefinite appropriations. The contingency fund has been requested to cover any shortages resulting from unanticipated costs in retirement payments, survivors' payments, and/or medical care. The contingency fund has been requested to prevent the necessity of making a supplemental budget request should the actual costs exceed the estimate.

Question: Please explain your proposal to eliminate coverage of medical benefits under this account for the Coast Guard and the National Oceanic and Atmospheric Administration. How were these two groups selected and who will pick up these medical benefits?

Answer: In the past this account has included funds for medical care for the dependents of commissioned officers of the National Oceanic and Atmospheric Administration (NOAA), the Coast Guard, and the Public Health Service. In Fiscal Year 1983, this change was made in the proposed budget in order to improve the relationship of the budget to program responsibilities. NOAA and the Coast Guard are requesting funds for their dependents' medical care previously budgeted in this account.

HEALTH PROMOTION

Question: Why is the Department requesting twice as much money for Fiscal Year 1983 as was available for Fiscal Year 1982?

Answer: Health promotion is among the Department's highest health priorities. The request restores funding to the 1981 level for a solid health promotion program. This will allow the Department to sponsor the following activities:

- o Continuation of cooperative agreements with approximately 3,000 local chapters of the Red Cross, YMCA, Urban League, Hispanic and other voluntary organizations;
- o Formation of cooperative agreements with the Chamber of Commerce, to expand work-site programs; the Association of Chief State School Officers, to expand the emphasis on school health education; and the Advertising Council, to sponsor a continuation of the National Health Promotion Media Campaign.
- o Work with the Business Roundtable to increase health promotion efforts at the worksite;
- o Coordinate efforts with the Governors' Association on School Health Curricula;
- o Operation of the National Health Information Clearinghouse;

- o Implementation of national measurable objectives in prevention;
- o Provision of technical assistance to public and private sector on health promotion efforts.

Question: What duplication or overlap exists between the health promotion/disease prevention activities carried out by the Office of Health Information and Health Promotion and those supported by the Preventive Health and Health Services block grant?

Answer: The programs are not duplicative; rather, they are reinforcing. The block grants have been designed to give the States the capabilities to develop and target preventive and other health service programs tailored to local needs. The work of the Office of Health Information and Health Promotion is designed to provide national leadership for those efforts in the health promotion area. That is, the Office of Health Promotion works to provide technical assistance to States and localities seeking to implement programs under the block, and also works to stimulate and facilitate involvement of the private sector in health promotion efforts at all levels.

Question: What national priorities are not being met through the Centers for Disease Control's program on Health Promotion and Risk Reduction which warrant funding through your Office of Health Information and Health Promotion?

Answer: The Office of Health Information and Health Promotion (OHIHP) bears principal responsibility within the Department for ensuring that all of the Department's health promotion activities (e.g., those in NIH, ADAMHA, HSA, FDA, as well as CDC) are coordinated, consistent and effective. As such, the OHIHP is the principal policy office for health promotion activities in the Department. It also serves as the prinicipal focus for coordinating the involvement of the Department with private and voluntary sector health promotion and health information activities. The CDC program places greater emphasis on delivery of health promotion services, research and evaluation in health promotion, and links with the health education community.

Question: What are the specific goals that you want to accomplish with your health promotion activities in Fiscal 1983?

Answer: Specific goals for 1983 include:

- o Completion of the operational plans for the National Health Promotion Training Network which utilizes the resources of 3,000 local chapters of the Red Cross, the YMCA, the Urban League and the Coalition of Hispanic Health and Mental Health Organizations.
- o The formation of a cooperatiave agreement with the Chamber of Commerce to expand the number of worksite-based health promotion programs for employees.
- o The formation of a cooperative agreement with the Association of Chief State School Officers to expand the emphasis on

school health education in the program of our Nation's school districts.

- o The formation of a cooperative agreement with the Advertising Council to sponsor a continuation of the National Health Promotion Media Campaign.

Question: What are the highest priorities in health promotion in the Department at the present time?

Answer: The principal intent of the health promotion program is to raise the awareness of individuals about the controllable risks which impinge upon their lives and the extent to which those risks can impact on health status as well as the extent to which they can be controlled. Our highest program priority is insuring that national efforts in risk reduction are well coordinated and mutually reinforcing. To this end, special emphasis is placed on working with large voluntary organizations that have multiple local chapters and working with coalitions of business and industry groups which have access to large numbers of employees. Health promotion generally includes a broad set of activities designed to facilitate behavior changes conductive to health. This can be behavior related to nutrition, to exercise and fitness, to smoking, to alcohol and drug misuse, to stress management. Each of these behaviors is important to health status and health outcomes, but the important thing to bear in mind with respect to program activity is that the behaviors are frequently linked one to the other, and, therefore, approaches to enhancing behavior on these dimensions must also be linked.

Question: Will there be any new initiatives in health promotion in Fiscal 1983 that the Department has not attempted in the past?

Answer: While the overall focus will remain the same -- enhancing the awareness of controllable health risks among the general population--the Department will continue to try to find new avenues of reaching its goals. Consequently, new cooperative agreements will be effected with the Advertising Council, the Chief State School Officers, and the Chamber of Commerce. Furthermore, we will be working to facilitate access to health information within the Department by exploring and possibly developing a common access point through the umbrella of the National Health Information Clearinghouse.

Question: What percentage of your funds is used for administrative costs, overhead expenses, and personnel costs?

Answer: In Fiscal Year 1983, it is estimated that 46 percent of the budget will be used for personnel, overhead, and administrative costs.

Question: What portion of your funds is set aside for sponsorship of cooperative agreements with major national organizations?

Answer: For FY 1981, approximately $175,000 of the total health promotion budget of $2.3 million was used for cooperative agreements with four major national organizations. Due to budget constraints, no funds are available for FY 1982. However, in FY 1983 aproximately $325,000 is planned to be set aside for cooperative agreements with major national organizations.

Question: What percentage of your funds is used for travel or meetings?

Answer: In Fiscal Year 1983, it is estimated that 3 percent of the health promotion budget will be spent on travel and meetings.

SMOKING AND HEALTH

Question: What role did the Office on Smoking and Health play in formulating the recently released Surgeon General's Report?

Answer: As in previous years this Report was prepared under the general editorship of the Office on Smoking and Health. The Office was assisted in the preparation of the Report with the aid and critical review of dozens of experts from within and outside the Government.

Question: Do the results of the study indicate the Office on Smoking and Health is effective?

Answer: The Government has maintained a leadership role focusing national attention on the hazards of smoking for over 16 years through the Office on Smoking and Health and its predecessor the National Clearinghouse on Smoking and Health. Declines in per capita consumption and reduction in the number of smokers have correlated with vigorous national attention to the smoking problem. The existence of a focal point providing technical assistance and scientific and technical information at the Federal level has stimulated State and local governments, voluntary agencies and community level organizations to assume greater responsibility for smoking intervention activities.

Since 1978, when the Federal smoking effort was given renewed emphasis, substantial progress has been made as indicated by the following.

- Per capita cigarette consumption has declined at a greater rate than in any period since the late 1960's. It is now at the lowest level since 1957.
- Over 33 million Americans alive today have quit smoking.
- A net increase of 1.8 million former smokers occurred during the period 1978-1980.
- Fewer men smoke cigarettes today, proportionately, than at any time since Government records began in 1955 — perhaps since the 1920's.
- Cigarette smoking among boys is probably lower today than at any time since the 1920's and 1930's, and smoking among younger girls has dropped sharply in the past five years.

- During the past 3 years, a substantial decrease has taken place in the tar and nicotine yields of cigarettes. Seventy-five percent of all brands marketed today are in the 15 mg. or less tar category.
- Since 1978, the number of smoking research projects worldwide has increased approximately 16% with the major growth occurring in the behavioral sciences and other areas targeted by the Federal government as areas of need.
- Inquiries from the scientific community are at an all time high averaging 200 per month in 1979 and totalling 4,500 in 1980. Requests for information from the public in 1980 totaled over 30,000.
- Circulation of scientific publications increased by 25% in 1980 to over 5,000 recipients.
- In excess of 120 smoking intervention demonstration projects have been initiated at the community level.
- State level smoking intervention and education activities have been initiated by each of the 50 State Health Departments.

Question: What changes in strategy does the report suggest for the Office on Smoking and Health? Is more money necessary, a different focus, an altered approach to the problem?

Answer: The Surgeon General's 1982 report attributes some 30 percent of all cancer deaths to cigarette smoking and establishes smoking as the chief preventable cause of death in our society. The report does not call for changes in strategy, but for an increased efficacy with available funds. This effort should reach young people, to persuade them not to take up smoking and adults, who would like to quit smoking. It also calls for encouragement of lower-yield cigarettes for those who have not yet quit, although with the caveat that smokers should not increase their smoking upon taking up the lower-yield brands.

Question: What evidence does the Department have which would indicate whether the activities of the Smoking and Health Program have directly contributed to the reduction of the prevalence and number of cigarette smokers?

Answer: There is ample evidence that the public responds to health information about smoking when it is sympathetically and effectively presented and when the accuracy of the information is unassailable. The Department's smoking and health program, in existence since 1966, has played a major role in bringing about the decline of smoking in this country. The program's most active years were in 1966-1972 and since 1978, when it has had notable success in its own programs and in working with the voluntary agencies and other programs in the Federal government. Corresponding declines in consumption took place during the late sixties and early seventies and since 1978.

Declines in cigarette consumption have taken place in response to Government and voluntary effort. Consumption dropped after the Surgeon General's Report of 1964, during the antismoking television campaign from 1968 to 1971, and has dropped over the past four years of activity by the Office on Smoking and Health.

Very recent data from the National Health Interview Survey (March 1981) reveal that in the three years of the present Office effort, the number of former smokers in the population has increased from approximately 31.5 million to 33.3 million. Fully 60 percent of these newly-quit smokers are women. It was during this period 1979-81 that the Office's public information and education activities targeted smoking by women and the 1980 Report was *The Health Consequences of Smoking for Women.*

Question: In what ways do the activities of the Office on Smoking and Health overlap functions performed by the Office of the Surgeon General?

Answer: There is no overlap. The Office is situated, as is the Office of the Surgeon General, within the Office of the Assistant Secretary for Health. The Surgeon General, institutionally and as an individual, plays a major role in helping develop and direct the smoking and health policies of the Department and the programs of the Office on Smoking and Health.

Question: What research is being conducted within the Department to determine why people begin smoking and how behavioral patterns might be altered?

Answer: Much of the public and private research being carried on in the smoking and health area is now turning from biomedical to behavioral research. Among the questions being asked are who smokes, how they took up smoking, and what problems these smokers face in quitting and staying off cigarettes. Research is now being carried on intramurally and through grants and contracts by the National Cancer Institute the National Institute of Drug Abuse, the National Heart, Lung and Blood Institute and the National Institute of Child Health and Human Development. Important research tools are surveillance studies of smoking behavior by adults and by young people. Budget constraints in some areas have slowed the behavioral research effort.

Question: Does research indicate one method over another as being the most effective method by which one can stop smoking?

Answer: There appears to be no single "best" method of quitting. Most people who quit do so on their own, but others find it beneficial to take part in cessation programs. Motivation appears to be most important, along with support from family and friends.

Question: By what method does the Department determine the most effective approaches to use in order to reach and educate a particular segment of the smoking populace (and thereby discourage them from smoking)?

Answer: Each of the recent reports of the Surgeon General has surveyed the various approaches which can be used to reach and educate the public about smoking. The approaches as might be expected, vary from one group to another. The Department's information and education materials are developed in accordance with this research, with specific audiences in mind, and are subjected, before release, to rigorous pre-testing.

Question: What new activities will be undertaken in fiscal year 1983?

Answer: The restoration of the Office's budget to 1981 levels will permit continuation of the program with minor improvement in technical information activities, but will not allow the development of new programs.

HMO LOAN AND LOAN GUARANTEE FUND

Question: What is the current status of the Loan Fund?

Answer: As of December 31, 1981, the Revolving Fund had an actual balance of approximately $11.6 million. However, the majority of notes in the portfolio are low interest notes (8 percent and below) and OHMO would absorb significant discount losses on their sale to the Federal Financing Bank (FFB). Therefore, the effective balance would be approximately $5.5-$6.0 million.

In order to meet current liabilities OHMO has been forced to let defaulted notes held by the FFB remain there, with OHMO making semi-annual payments of principal and interest to the FFB on these notes. As of December 31, 1981, $19.3 million in defaulted notes are held by the FFB and an additional $9.6 million is expected during the remainder of FY 1982. In FY 1982, OHMO will pay approximately $3.6 million to the FFB in semi-annual payments of principal and interest. Absorbing these payments has allowed OHMO to continue to revolve the fund without additional appropriations.

Question: What is the status of the phaseout of the program?

Answer: Currently OHMO plans to award operating cost assistance loans in FY 1982 and 1983. A total of 12 awards are projected in FY 1982 and 8 for FY 1983.

Question: How many applications for loans and loan guarantees are "in the pipeline"?

Answer: Of the 12 operating cost assistance loans OHMO expects to award in FY 1982, 10 are expected to go to developing HMOs that have received Federal grant funds. All 8 awards projected for FY 1983 will go to developing HMOs that have received Federal grant funds. By the end of FY 1983 all grantees will have completed development and, where necessary, received operating cost assistance loans.

Question: How many applications for loans and loan guarantees for initial costs of operation and for ambulatory care facilities have been from private health maintenance organizations?

Answer: OHMO has received a total of 11 applications for operating cost assistance loans from private HMOs (HMOs developed without Federal grant funds). In addition, 4 applications for operating loan guarantees and 1 application for an Initial Development loan guarantee have been received. All of these applications were approved. Also, OHMO has received 1 application for a construction loan guarantee for an ambulatory care facility. This application was denied.

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH

Question: Can you briefly outline for us some of your most significant accomplishments during the past year?

Answer: The National Center for Health Services Research (NCHSR) is a research organization. As such, it is not directly involved in formulating, choosing or recommending specific policies. Its task is to provide information and the results of experience to those who determine policy. Over the past year, the NCHSR has produced research findings that could infludence health legislation, policy debates, Departmental programs, and/or the health care delivery systems. Examples of these findings include:

- A screening protocol that recommends X-rays for patients exhibiting any of 14 clinical indicators has shown a reduction in unnecessary X-rays of limb injuries. Adoption of this protocol could save between $79 and $139 million nationwide without compromising quality of care.

- The potential for cost savings to the American consumer--taxpayer as a result of generic drug substitution laws is nearly $3 billion. However, pharmacists actually substitute in less than six percent of prescriptions.

- Estimated savings of $30 million, or 20 percent of State expenditures on Cardiac Care Unit (CCU) care (1977 data) could be achieved through tightening CCU admissions and discharge practices. Even greater savings would result, without compromising the quality of care, if hopitalization for simple acute myocardial infarctions (AMI) were limited to seven days, and selected AMI patients received home treatment.

- Utilization of the proper selection and implementation strategies suggested by a workbook developed to assist hospital decision-makers in the activities related to the acquisition, use, and management of Automated Hospital Information Systems (AHIS) could result in an annual savings of $50 million. Given that the AHIS industry projects billings between $1 and $2 billion a year, use of this workbook may result in a significant savings to hospitals.

- The Federal Government lost $8.0 billion in 1977 (and an estimated $20 billion in 1981) in potential revenue due to the tax treatment of employer provided health insurance premiums. Previous estimates by the Treasury Department for 1977 were $5.6 billion, substantially less than the new, more accurate, NCHSR estimate.

- A home based emergency alarm and response system for the elderly living alone and functionally impaired reduced by 75 percent the use of institutional care and other community health services.

- Sixteen percent of total Medicaid drug expenditures could be saved by the introduction of a national capitation program for Medicaid reimbursement for drugs.

Question: What kinds of innovations are now being marketed by private industry which were the result of NCHSR research?

Answer: Past research supported by NCHSR has provided the basis for a number of innovations now being marketed by private sector. Examples of these innovations include:

- The development and dissemination of the Massachusettes Utility Multi-Program System (MUMPS) computer language which was specifically designed for medical use. This language has been adopted for use in more than 5,000 medical, business, industrial, and government facilities around the world. Over 20 computer manufacturers now market systems using the language allowing MUMPS products and services to be exported worldwide.

- Computer Stored Ambulatory Record (COSTAR), developed under an NCHSR research grant to the Massachusettes General Hospital, is the most widely used computer stored medical record system in the United States. There are now over 20 commercial vendors employing hundreds of computer technicians to market and install COSTAR in small group practices.

- NCHSR supported the demonstration and dissemination of Electrocardiogram Analysis (ECAN), one of the initial computer programs which permitted on-line analysis of electrocardiogram (ECG) signals. This research has generated development of private industry that now provides ECG systems and analysis to thousands of hospitals and private practices.

REGULATIONS

Question: To what extent will research activities be redirected toward determining the relief from inflation which could result from eliminating certain health care regulations?

Answer: NCHSR supported studies which deal with the social costs of regulations will become increasingly important for a procompetitive strategy. For example, a recent study showed that State laws regulating dental practices may have driven up prices by restricting the number of hygientists that can be employed and by not allowing for reciprocal licensing agreements between States. Another supported study found that State bans on optometric advertising effectively raised prices of eye examinations an average of nine percent above those prevailing in areas that did not ban advertising. When combined with other regulations forbidding the employment of optometrists by corporations, prohibiting the establishment of branch offices, and requiring optometrists to obtain continuing education, the average cost of eye examinations was found to be 32 percent higher.

RESULTS OF RESEARCH

Question: Could you give us some examples of a direct saving which resulted to the States because of programs which they have implemented through recommendations the NCHSR?

Answer: The Department of Health Services, County of San Diego has led in the adoption of the Computer Stored Ambulatory Record (COSTAR) system which was developed under a Center grant as a means to reduce the impact of decreasing Federal and State matching funds and the increasing demand for county-provided primary care services. Preliminary data from the initial nine clinics using COSTAR in San Diego County show general revenue increases of approximately 30 percent.

Ten other California county health departments are now in various stages of implementing COSTAR systems that replicate or expand upon the San Diego experience. The expanded applications will take advantage of COSTAR's powerful medical record storage and retrieval capability to integrate primary care services with other county-provided services in the areas of tuberculosis, venereal diseases, immunization planning and vital statistics. This positive fiscal impact of COSTAR systems in California is now drawing the attention of health care administrators and providers in many other states.

Center supported research has investigated the potential of cost savings to the American consumer-taxpayer of drug substitution laws. Based on studies in Michigan, Wisconsin, Rhode Island, and Vermont, it is estimated that the potential for savings in this area is nearly $3 billion. However, pharmacists actually substitute in less than six percent of prescriptions. These findings and strategies for optional drug substitution laws were reported before State legislatures in Indiana, Hawaii, Michigan and Kentucky.

NCHSR supported an experiment whereby pharmacists were reimbursed on a capitation basis rather than a traditional fee-for-service system. The change in the method of reimbursing pharmacists led to a six-fold increase in the rate of generic drug substitution. If the findings from this study hold up in an extended study, the total saving to the Medicaid program, if all States adopted capitation payment to pharmacists, would be 16 percent of total drug costs, or approximately $210 million.

Question: To what extent has research sponsored by the NCHSR during the last three years led to changes in health care policies?

Answer: Changes in health policies directly related to Center studies include:

- The Utah Department of Health is currently making arrangements to utilize a computer-simulation model designed to forecast Medicaid expenditures.

- In the State of Connecticut, the Vice Chairman of the Public Health Committee in the Connecticut House of Representatives has established a new evaluation and monitoring process for one of the state's Respite Care programs. A generic process for program evaluation and monitoring has been developed under Center sponsorship.

- As a result of NCHSR dissemination of descriptive information on the Nursing Home without Walls Program in New York State, legislation has been proposed in the 1982 session in the Hawaii House of Representatives to provide for development of a similar program for Hawaii's elderly population.

- The Florida Department of Health and Rehabilitative Services is currently utilizing the research findings presented in an NCHSR synthesis on HMO operations and performance to determine how Medicaid recipients can be served more effectively through county-based pre-paid health care plans.

- An synthesis of research findings on options and strategies in the design of State and long-term care programs is currently being utilized by the Pennsylvania Department of Health in connection with the activities of the Governor's task force on this issue.

- As a follow-up to the Center's User Liaison Program's workshop on perinatal centers, the State of Florida is drafting legislation to fund the system of regionalized perinatal centers.

- Tax Exclusions for Employer-Financed Health Insurance Premiums - through its National Health Care Expenditures Study, the NCHSR has provided improved estimates of the revenues lost as a result of excluding employer-financed health insurance premiums from emplyees' taxable income. Staff of the NCHSR and the Department of HHS are working with the Congressional Budget Office in the consideration of legislative proposals to limit employer premium contributions or the tax exclusion to increase Federal revenue.

- Medicare Supplementary Insurance - the Center is assisting in the assessment of currently available "Medigap" insurance policies and the need for legislation to ensure their adequacy and combat marketing abuses.

DISSEMINATION

Question: What mechanism is in place to assure that research findings of the NCHSR are thoroughly disseminated throughout the country?

Answer: The Center supports an active program to disseminate the results of research projects which it has assisted or undertaken. The dissemination program can be characterized by two general types of activities: a State and Local User Liaison Program and a Publications and Information Program. The dissemination program provides relevant information to the health services research community and to those involved in the organization, administration, and delivery of health services and in the formulation and implementation of health services delivery policies. The dissemination program also reflects the provision in the legislation which requires that at least $1 million or five percent of the budget, whichever is less, be used for dissemination activities.

The User Liaison Program has engaged in the following types of activities.

- o Dissemination workshops for users were organized in cooperation with one or more cosponsors. During 1977-1981, 23 dissemination workshops were attended by such users of health services research as State legislators, State and local health planning officials, city health officials, and leaders from the insurance industry and hospital sector.
- o Priority review meetings were held which offers users from State and local organizations an opportunity to review with senior NCHSR staff the priority issues currently being addressed or planned for by the NCHSR research program.
- o Five day workshops were held for State and local health leaders that provide users with an exposure to health services research methods and an enhanced ability to interpret and utilize research studies.
- o Center staff and distinguished researchers from around the country participate with local representatives in discussions of the selected topics. This type of participation assures that health services research expertise is brought to bear on local issues and expands the forum for the exchange of problems, ideas, and information.
- o User liaison efforts have fulfilled specific requests for individuals for information and assistance in topics pertinent to their particular needs and operational problems.

The publications and information program is designed to present the results of research which NCHSR has conducted or supported in a manner that makes it helpful to a concerned public as soon as possible. To assure a wide distribution of research reports and data tapes produced through individual research projects, NCHSR provides all final reports and public use tapes to the Commerce Department's National Technical Information Service (NTIS). The NTIS announces the availability of such information and arranges for its distribution to the public. NCHSR research reports also are made accessible to the public through placement in various libraries.

FUNDING INCREASE

Question: The budget request for the research program includes an increase of $906,000. Can you outline the reason for this increase?

Answer: This increase will support additional research projects in the priority areas of health promotion/disease prevention and technology assessment. The potential for significant improvement in individual health status through health promotion and disease prevention is receiving increasing attention. These efforts are becoming especially important because chronic diseases, such as heart disease and cancer have replaced communicable diseases as the leading causes of lost years of productive life, and cost to the society in medical expenditures and long term care.

Other Federal agencies particularly the National Institutes of Health and the Food and Drug Administration, evaluate the safety and efficacy of specific technologices but it is the NCHSR research activity that encompasses the effectiveness, cost-effectiveness, and the social, ethical, and economic impacts of health care technologies. Such research routinely takes into consideration relevant studies and activities undertaken by other Federal departments and agencies. In 1983 consideration will be given to projects developing and defining methodologies having the potential for wide-spread application. Examples of areas where such research is needed include: quicker methods for assessing rapidly changing technologies; more feliable measures of effectiveness, risk, benefit, and cost; better short-term outcome measures of effectiveness; less costly techniques, using secondary or existing data sources for assessments and evaluation; and improved strategies for information retrieval applicable to technology assessment.

COMPETITION

Question: To what extent will the National Center for Health Services Research conduct research on the subject of competition in the Nation's health care system?

The Center has been supporting work related to competition for several years and will continue to do so in Fiscal Year 1983. Research supported has directly influenced such health legislation as the Health Maintenance Organization Act and is now being used in developing the Administration's Competition Bill. Examples of research findings in the area of competition include:

- A study of the Seattle Prepaid Health Care Project compared the competitive effects of two prepaid health plans: prepaid group practice and independent group practice. Costs of the comprehensively-insured independent practice were 50 percent higher than the group practice costs, and the quality of the process of care was even better in the group practice.

- Regulation of optometry services by states which limits competition through bans of advertising and other normal market practices raises the price of an eye examination by 32 percent.

In 1982, NCHSR will release a new, three-part publication on "Competition in the Financing and Delivery of Health Services." This document will include an annotated bibliography which will provide the first concise overview of a wide range of research findings concerning the impact of diverse market forces on the health care system; a narrative discussion of this material will synthesize the insights to be gained from the research findings; and a summary of policy issues will relate them specifically to current legislative and regulatory questions.

This project and the resulting activities were undertaken to assist NCHSR in making an informed assessment of the direction that future research in this area should take. Consequently, during Fiscal Year 1983, the NCHSR will implement new research projects in the area of competition which were generated through this and other consultations. NCHSR will sharpen its focus on a better understanding and analysis of the operations of the health care market, including the responsiveness of prices, productivity, and health expenditures to the supply and organization of providers and facilities and to fiscal incentives. Public and private strategies necessary to achieve a desirable combination of expenditure control and adequacy of services will receive analytical attention.

TECHNOLOGY ASSESSMENT

Question: To what extent will the NCHSR pick up the responsibility of the National Center for Health Care Technology for making recommendations to the Health Care Financing Administration on the appropriateness of Medicare reimbursement decisions?

Answer: The Center has assumed responsibility for supporting research in the area of health care technology assessment. Recommendations to the Health Care Financing Administration on the appropriateness of Medicare reimbursement decisions are now being administered by the Office of Health Research, Statistics, and Technology. The present plan is to continue this activity within the Office of the Assistant Secretary for Health until a review of the entire technology assessment responsibility is completed.

HEALTH PROMOTION

Question: Dr. Brandt mentioned that an emphasis would be placed on research dealing with health promotion. Could you outline for us in more detail the kinds of areas such research might cover?

Answer: The potential for significant improvement in individual health status through health promotion and disease prevention is receiving increasing attention nationwide. These efforts are becoming especially important because chronic diseases, such as heart disease and cancer, have replaced communicable diseases as the leading causes of morbidity, mortality, lost years of productive life, and cost to society in medical expenditures and long-term care. Since many chronic diseases arise from or are complicated by multiple causes, including behavioral and environmental factors, a more comprehensive approach to health care is emerging. This comprehensive approach is reflected in research on health promotion and disease prevention being supported by the Center. Examples of resultant studies underway in Fiscal Year 1982 and Fiscal Year 1983 include:

- "Special Packaging and Hypertensive Control." This study is testing a technique to increase compliance with hypertension medication regimens in a clinical setting. Its target group is low-income middle-aged Blacks with uncontrolled hypertension, a particularly high risk-population.

- "Physician Effectiveness in Patient Care." Findings from this study will provide information for the physician provider on those interventions that would be most useful in increasing patient compliance with physician recommendations for health or prevention behaviors. There is little information available currently as to the most effective method physicians can use to achieve health promotion/disease prevention objectives.

- "Evaluating Preventive Medical Care as a Health Strategy." The results of this study will be a guide to what factors need to be considered when specific proposals for health promotion and disease prevention programs are made. The study will examine the costs and benefits of prevention as opposed to the costs and benefits associated with treatment.

- "Health Promotion - Ethical and Social Dilemmas of Government Policy." The results of this study will provide guidelines for governmental and private decision makers on the "pros" and "cons" of various efforts to promote behavior change. The complex ethical, social, economic, political and legal issues involved in a decision to attempt to modify behavior to promote health will be described as well as possible options based on these described issues.

In Fiscal Year 1983, the Center will support research in the area of health promotion and disease prevention which analyzes the organization, delivery and impact of activities, services and programs which are designed to improve the prevention of disease and the promotion of health. The interest in prevention and promotion activities stems from many sources including changing patterns of morbidity and mortality in the United States, shifts in the age composition of the population, and growing knowledge of the impact of personal behavior. In addition, concern about the accelerating costs of medical care has brought with it the realization that a growing burden of expenditures for illness may be associated with treatment practices with very limited improvement in health status. The NCHSR health promotion and disease prevention research agenda will include studies which address the following areas:

- Health Status Measurement - to seek increased understanding of the distribution and determinants of human disease and disability critical to the prevention of illness.

- Organization and Provider Studies - to examine their influence on the effectiveness and efficiency of services delivery.

- Analysis of Public/Private Program Interventions - to examine the successes or failures of promotion and prevention programs with respect to the different kinds of administrative arrangements employed.

- Consumer Knowledge, Attitudes and Behavior - to examine aspects of consumer behavior that fosters or inhibits prevention performance.

NATIONAL CENTER FOR HEALTH STATISTICS

Question: The budget request for program operations for the Center for Health Statistics includes an increase of $3,244,000. What is the reason for this increase?

Answer: The 1983 budget request provides an increase of funds for two major surveys. The first allows the expansion of the Hispanic Health and Nutrition Examiation Survey to include, in addition to Mexican-Americans in the Southwest, two additional Hispanic population groups, Puerto Rican Americans and Cuban-Americans. The second increase provides for the orderly growth of the National Health Interview Survey to allow the collection of important trend data and special health topic data. These two major surveys are the only source of national health data for the incidence of illness, prevalence of diseases and impairments, extent of disability, utilization of health care services and other measures of the health of the nation as well as for vital information on the nutritional status, growth and development of children and other special health characteristics of our Hispanic minority population.

Question: Given our budgetary constraints, what action is being taken to rank your activities by priority? Have you looked at the possibility of collecting data for certain programs on some basis other than annually? Have you made any estimate of savings which might accrue on this basis, without adversely affecting the research being conducted?

Answer: Recognizing the need to continue to provide baseline health data useful for trend analysis, yet cognizant of the very likely possibility of future resource constraints, the National Center for Health Statistics (NCHS) undertook and recently completed a thorough review of its priorities and program plans. The results of that review, including an estimation of cost savings, are detailed in the report "Periodicity of Data Systems: A Data Collection Plan for Fiscal Years 1981-86." The results of this study, and the changes we are implementing based on it, represent a statement of the data collection priorities of NCHS.

In developing the report we attempted, within budget constraints, to maintain the program of national level health information that is required for development and implementation of national policies and programs. We have limited our future data collection to those areas for which information is not available through other public or private sources. For example, activity in the health professions statistics area has been sharply curtailed since health professional associations produce much of this information. The data systems of NCHS will provide national baseline descriptive information on vital events, health status, and the delivery and cost of health care. The information will be useful for planning and evaluating Federally financed health programs, identifying areas of health care needs, and targetting of research funds. Although we will continue to provide a wide range of information, there will be limited geographic detail, lack of analytical depth, and greater reliance on either ad hoc or periodic rather than continuous data collections. Data will be provided through the national vital statistics system and our program of interview surveys, supplemented by facility and provider surveys, and should be useful for monitoring aggregate effects of block grants.

A few examples of recommendations in the Periodicity Report may well illustrate the nature and extent of changes to NCHS programs:

- o The household survey of medical care utilization and expenditures for that care will be conducted every four years rather than on the previously planned cycle of every three years.
- o The survey of physicians to obtain information on ambulatory care provided in the private physician's office has been conducted annually since 1973. That survey is not being done this year and in the future that information will be collected every three years.
- o The census we maintain of health facilities will now be updated triennially rather than the previous biennial cycle.
- o Information on nursing homes including characteristics of the residents, staffing patterns, and costs and charges will be updated only every six years. Previously we had planned to do this every three years.

These examples are meant to be illustrative of the changes that can be expected in the currency of available health data. In addition to simply changing frequency of data collection, we have reduced sample sizes, modified quality control procedures, and made cutbacks in our publications plans.

A particularly critical and promising objective of our research program is to develop uniform methods of designing the Center's surveys. This will greatly expand the analytic potential of the data generated and reduce the costs of the individual surveys.

Question: Do you have figures on a "turn-around" time for health data collected through your program, that is, from the time information is collected? How long does it take before the data is available for public consumption?

Answer: The National Center for Health Statistics (NCHS) regularly operates more than a dozen different data systems. The turn-around time varies, of course, by the type of data under consideration.

Vital statistics are collected on a continuous basis. Vital events, such as births and deaths, are registered locally, underthe civil laws of the respective States, at the time they occur. Each State then, at intervals, transmits either microfilm copies of the vital certificate or machine readable tapes to the NCHS. In order to ensure the timely detection of any new trends, as well as to provide maximum detail for epidemiologial and demographic analyses, the Center releases provisional estimates with quick turn-around and final, definitive, detailed statistics on a longer timetable.

Provisional estimates are published monthly. Each month's report covers the period ending approximately ten weeks prior to the publication date. Estimates are available concerning births, deaths, infant deaths, marriages, and divorces. Certain broad estimates are made on a State-by-State basis. The monthly provisional estimates have proven to be generally quite accurate and useful for general trend analysis, but they cannot provide the diagnostic and geographic detail needed for other specific purposes. Aggregating provisional data for entire years permits somewhat more detailed estimates. Annual provisional figures are published between five and ten months after the end of the year. However, final annual statistics in considerable detail are both published as well as released to users on computer tape within about 18 months of the data year.

ENVIRONMENTAL/HISPANIC STUDIES

Question: What is the current status of the environmental health and the Hispanic nutrition studies?

Answer: A series of specific responsibilities were assigned to the National Center for Health Statistics (NCHS) under the environmental health provisions of Public Law 95-623. The statutory requirements and NCHS' progress in fulfilling them are:

- Developing a plan for the collection and coordination of statistical and epidemiological data on the effects of the environment on health (Sec. 306(1) 1): NCHS staff developed the plan and incorporated the suggestions and obtained the concurrence of the 18 governmental agencies that maintain relevant data systems as well as the several additional organizations specified in Sec. 306(1) 4. In accordance with the statutory requirements, the Secretary of Health and Human Services transmitted the plan to the Congress during fiscal year 1980.

- The establishment of guidelines for the collection, compilation, analysis, publication, and distribution of statistics and information necessary for determining the effects of employment and indoor and outdoor environmental conditions on the public health (Sec. 306(1) 2):

- The development of a clearinghouse for statistics and information with respect to which the (foregoing) guidelines have been established (Sec. 306(1) (2) D): Since the content of the clearinghouse depends on the guidelines, definitive developmental steps cannot be taken until investigation of clearinghouse activities in other agencies has been performed by NCHS.

- The conduct of a study of the issues respecting, and the recommendations for establishing, a Federal system to assist in locating individuals exposed to hazardous substances to determine the effect on their health of such exposure and to assist them in obtaining appropriate medical care and treatment (Sec. 306(l) 3): The report was submitted to the Congress by the Secretary of Health and Human Services during January 1981.

- Initiate, working through the Institute of Medicine of the National Academy of Sciences, an ongoing study of the present and projected future health costs of pollution and other environmental conditions resulting from human activity (Sec. 304(d) 1): A planning study was conducted by the Institute of Medicine (IOM) under contract with DHHS and with active NCHS staff participation as resource persons for the IOM Committee. Secretary Schweiker transmitted the IOM report, "A Plan for Continuing Study--Costs of Environment-related Health Effect," to the Congress on August 3, 1981. In his letter of transmittal, the Secretary indicated that it would be premature to establish the cost study on a continuing basis. He stated:

> Given present scientific uncertainty about the extent to which particular exposure to toxic substances cause or contribute to disease, the Department feels it essential to continue research in the relevant biological, behavioral and social sciences necessary to fill crucial gaps in the knowledge base required for the proposed ongoing study.
>
> We will keep the Congress fully informed of relevant advances, and report in two years on the state of knowledge necessary for full implementation of the proposed study. Should knowledge and resources permit at that time, further discussions of the administrative arrangements and funding necessary to conduct the study will be undertaken.

Several DHHS components are actively prosecuting the fundamental scientific investigations that are prerequisite to the ongoing cost study. Section 304(d) 1, was amended through the Budget Reconciliation Act of 1981. The new language has: "The Secretary, with the advice and assistance of the National Academy of Sciences..." The original version had required that the study be conducted "jointly" by the Secretary and the National Academy of Science (NAS). The NAS, in its Plan for the Continuing Study, requested the change in wording since its charter prohibits the Academy from compromising its independence, as it might by entering into a joint study. The Budget Reconciliation Act also changed the reporting requirement to every third year rather than every second year.

The content and procedures of the Hispanic Health and Nutrition Examination Survey have been tested during pilot studies in Miami, New York City, and El Paso. The modifications required by the pilot studies are being made and the final OMB Clearance request is being forwarded for approval. A final pilot study is scheduled for San Antonio, Texas in June. The actual study will begin in the Southwest in July 1982. The current plan is to complete a study in selected Southwestern counties which would include interviews and examinations of approximately 8,000 Mexican-Americans, Puerto Ricans and Cuban-Americans in 18 locations. Additional locations in the New York, New Jersey and Miami areas will be included in the study bringing the number examined to 12,000 persons. The Southwest portion of the study is expected to be completed by December 1983. The remaining portions would be completed in 1984.

HEALTH MAINTENANCE ORGANIZATIONS

Question: In view of the termination of the HMO Grant Program, will you briefly outline for us the focus of major activities of the HMO program as it is presently constituted?

Answer: At this time the Office of Health Maintenance Organizations (OHMO) is involved in the following major activities:

- Private Sector Initiative - providing information to the investment community about HMO characteristics and performance in order to encourage investment in HMOs and to assist developing and operating HMOs in identifying sources of needed capital;

- Management Training/Technical Assistance - Management Training includes the National HMO Management Fellows Program, an 8-month program of classroom and field training designed to enhance the management skills of mid-level managers who are already working in HMOs, and the HMO Management Seminar Series, a series of seminars targeted at specific industry needs and designed for managers who can best be helped through short-term intensive training. Technical Assistance aids the development of new HMOs either by providing a single nationally recognized expert to provide assistance to HMOs on an individual basis in a specific problem area, or by providing a team of nationally recognized experts to provide consolidated technical assistance to HMOs experiencing major problems in several operational areas;

- Qualification - reviewing and conducting technical assessments of organizations to determine whether they meet all requirements for Federal qualification; and

- Compliance - monitoring all qualified organizations to assure the continued compliance with all regulatory requirements; monitoring loans and loan guarantees which support initial operating deficits of qualified HMOs; and monitoring employers for compliance with the mandatory offering of an HMO option.

Question: What is involved in the phasedown?

Answer: As of December 31, 1981, there were 36 active grants whose grant period will terminate during calendar year 1982. All of the active grants must be monitored during the remainder of the grant period to assure that they are meeting their target dates for completion of their developmental efforts. This is especially important for this group of grantees as there are no further grant funds which can be awarded to carry them through a longer than expected developmental period. The grantees must also be monitored to assure that they are developing their systems and procedures in such a way that they will be qualified and, more importantly, be successful in their operations. Technical assistance will be available and provided to these grantees as needed.

FINANCIAL ASSISTANCE TO HMOs

Question: How many of the Federally assisted, qualified HMOs currently in operation have a good chance of continuing operations without Federal financial assistance?

Answer: As of December 31, 1981, there are 126 Federally qualified HMOs and of those 51 are operational without any Federal loan monies at all, and could continue to operate without any Federal monies. Of the 75 HMOs that are operating with Federal loans, 13 have already reached a point of financial health (break even) and are no longer dependent on Federal monies. The remaining 62 HMOs are still dependent on Federal monies (Federal loans), and it would only be speculation as to how many of those would be able to reach breakeven if they no longer have Federal loan monies.

Question: How many do you estimate will be unable to continue operations without federal assistance?

Answer: There are 62 HMOs still dependent on Federal monies (Federal loans), and it would only be speculation as to how many of those would be able to reach breakeven if they no longer have Federal loan monies. It is not possible to project with any certainty the likelihood of these organizations obtaining private funding, however the program is actively encouraging the investment community to invest in HMOs while also assisting operating HMOs in identifying sources of needed capital.

RURAL HMOs

Question: Is there any particular category of HMOs which would be adversely affected by the phaseout, for example those HMOs serving rural or medically underserved areas?

Answer: Despite the phaseout of Federal support for HMO development the industry will continue to grow. However, the elimination of Federal funds for development removes one of the major sources of funds and future growth will be at a slower rate. Conceivably this slowdown will be more pronounced in rural and medically underserved areas. Private financing of HMOs will come primarily from investors seeking to develop for-profit organizations or from large employers wishing to develop HMOs to control their own health care costs. Because the population base in rural or medically underserved areas is usually small and/or low income, such areas are marginal for successful HMO development and, thus, not attractive to private investors. Likewise such areas do not normally have large employers who would have the capability (or interest) in developing an HMO.

Question: What action is the Department taking to help alleviate some of the particular problems which are involved in the establishment of HMOs to serve rural, low-income and medically underserved communities?

Answer: The Department is preparing a publication which will address some of the particular problems involved in developing an HMO in a rural area. This publication has been reviewed in draft and will be in final form in the near future. It will be made available to interested persons to assist them in establishing rural HMOs.

Also, through technical assistance contracts OHMO is providing technical assistance to developing and qualified HMOs in rural, low income and medically underserved communities. The chief vehicle for this assistance has been the Consolidated Technical Assistance contract. Under this contract experienced HMO administrators are sent onsite to review the HMO to determine the source of any problems they are encountering. This individual is then responsible for serving as a monitor for the HMO and assuring that on-site technical assistance to address these problems is provided.

Such assistance has recently been provided to the Hunter Health Plan in Lexington, Kentucky which has been operating as a Community Health Center in a low-income area and is attempting to convert to an HMO. This Plan has received technical help in developing its marketing plan, its financial plan and its clinic operations.

HMO DEVELOPMENT

Question: How many health maintenance organizations which have been funded in the past by the Federal Government, remain in the pipeline for development assistance?

Answer: As of December 31, 1981 there were a total of 7 organizations in the feasibility and planning stages continuing to develop with Federal grant funds. These organizations (5 in feasibility and 2 in planning) will have to secure private financing to continue development. Without private sector funding development will terminate. In addition, 10 grantee organizations in their initial development stage are expected to seek operating cost assistance loans in FY 1982 and 8 additional grantee organizations currently in their initial development stage are expected to seek loans in FY 1983.

Question: To what extent is private sector money available to allow federally funded health maintenance organizations to continue their development towards operation without Federal assistance?

Answer: Of 70 developing HMOs which were not Federally funded for the completion of their developmental activities during FY 1981, OHMO is aware of only 11 that have obtained private financing for the continuation of their development activities. While some others continue to pursue private financing sources, it is not expected that a significant number will be successful.

Meetings with existing and potential investors, as well as contacts in the financial community, indicate clearly that investing in developing HMOs is a "last and least" priority. Rather, potential investors will first consider successfully operating HMOs with a proven track record and assets that can be used to reduce their risk. Secondly, investors will consider an HMO that is operating at a deficit position, but for which management and capital infusion can make the difference between success and failure. No national HMO firms have indicated a willingness to continue the development efforts of the remaining projects. If these projects are to continue, it is expected that their financing will be community based through interested providers or employers.

Question: What is your estimate of how many health maintenance organizations the private sector has begun to develop in the past year?

Answer: Our estimate for new private sector HMO development during 1981 currently stands at ten organizations. This information gathered from various sources within the HMO industry is based on known activity which has progressed to a level of organized effort and which has become public knowledge. Three of these oranizations received some Federal funding at some point in time but no longer have Federal grant support. Private investors have since invested their resources into these plans for further development.

Sponsorship of the ten new, developing plans ranges widely from individuals in the immediate community to physician groups to major area employers to national insurance and investment firms. A majority of the developing plans project operational dates sometime in 1982.

Question: What kind of actions might be necessary to permit greater private development of HMOs--for instance, tax incentives or loan guarantees?

Answer: During 1981 the Congress passed legislation which provides specific incentives for business investment throughout the entire country. HMOs and other business organizations can and will benefit from this legislation. In addition to the investment incentives provided in this legislation, the following congressional actions would provide specific incentives for investors to seriously consider investment in Health Maintenance Organizations:

1. Tax-exempt revenue bonds - the U.S. Treasury is currently evaluating whether to restrict the eligibility of health care facilities and other organizations to use tax-exempt revenue bonds to raise capital.

   This source of capital is important for future HMO growth and development. Currently, two HMOs (Group Health of Puget Sound and Rutgers Community Health Plan) have taken advantage of this method for raising capital. It is expected that as the HMO industry grows and matures, many more HMOs will be able to use this source of financing.

If the U.S. Treasury finally decides to restrict eligibility on the use of tax-exempt revenue bonds, the restriction should not be applied to HMOs.

2. 501C3 Tax Status - in the past the Internal Revenue Service has applied very strict criteria in determining whether non-profit HMOs can receive 501C3 or 501C4 tax exempt status. Section 501C3 status is generally sought by almost all non-profit HMOs because it permits HMOs to receive tax-deductible contributions from organizations and the public. However, most HMOs have been unsuccessful in obtaining this tax status.

   Action which would enable HMOs to obtain 501C3 status more easily would benefit the HMO industry. Not only would HMOs be able to attract tax-deductible contributions from tax-exempt foundations, business, and the public; but it would also reduce the necessity for non-profit HMOs to become for-profit in order to obtain private financing.

3. Other tax incentives - OHMO is currently considering whether tax incentives designed to encourage employer endorsement of HMOs should be proposed. Broader support by employers for HMO enrollment would stimulate the investor community by helping to assure marketing success - one of the key factors in an investors decision to invest.

4. Reduced restrictions on highly regulated industries such as banks--federal and state banking regulations currently do not permit banks to invest in business sectors outside of banking and bank-related industries. There is only one exception to this restriction. Bank holding companies were granted a waiver in 1974-75 to enable them to invest in subsidized housing in order to reverse the trend of deteriorating communities.

   If the Congress took action to grant bank holding companies a waiver similar to the one stated above, the opportunities for HMOs to obtain equity financing would be greatly improved. Similar restrictions in other highly regulated industries should be identified and removed.

5. Loan guarantees - The HMO Act of 1973, as amended, authorizes the use of loan guarantees to cover HMO developmental and operating deficit costs. While the authority for such loan guarantee exists, it has been little used to date and is not seen as an effective method of stimulating greater private sector investment.

COMPLIANCE MONITORING

Question: What is the Department's procedure for dealing with financially unsound, federally assisted HMOs?

Answer: The OHMO compliance staff works very closely with state regulators, to rehabilitate and salvage troubled HMOs. If an HMO can be saved, OHMO will do everything within its power and authority to see that the HMO continues as a viable entity. If not, OHMO works with the state to see that the HMO is closed in an orderly fashion and that enrollees are protected from liaiblity and have continuity of care.

OHMO's technical assistance program includes the following:

1. Development Assistance to Initial Development (ID) grantees. OHMO is conducting Development Assistance visits to assist plans in completing their development and becoming financially viable HMOs.

   The focus of the ID Development Assistance is on ensuring that the development of the plan's finance, marketing, and health services delivery system will be responsive to the HMO's needs once it is operational. Substantial attention is paid during these visits to problems experienced by other operational HMOs so that adequate planning can be done by developing plans to avoid similar problems.

2. Early Operational Consultation. OHMO, in cooperation with the two major trade associations representing HMOs, has instituted a program to assist newly operational HMOs. This program provides experienced executives from successful HMOs to consult with the management of these new HMOs to help identify strengths and weaknesses in the HMO's operations and to follow up with assistance, if necessary.

   This program, which began in January 1982, requires visits to qualified HMOs which receive Federal loans during the first six months of operations.

3. Consolidated Technical Assistance. OHMO has in place a contract designed to bring intensive, coordinated technical assistance to an HMO which is experiencing operating difficulties. Under this contract, an HMO which shows signs of not meeting its operational budget or enrollment forecasts will be referred to a panel of persons with HMO operating experience who are recognized as experts in the HMO field. One of the members of this panel is assigned to visit the HMO to identify problem areas. This person, in conjunction with the other panel members, initiates a plan of action to address the identified problems. This includes the identification of persons capable of providing expert technical assistance to the HMO and in identifying for the HMO's Governing Board and administrative staff actions to be taken to resolve the problems.

4. Management Assessments. OHMO has a contract with an outside organization to visit qualified HMOs within the first year of operation to assess the management capability of the HMO's Board and executive staff. This contract also provides for limited training and provision of technical assistance to the Board and Chief Executive Officer.

HMO INSOLVENCY

Question: What safeguards exist to protect the members of HMOs which have failed?

Answer: As of December 31, 1981, 23 HMOs had failed affecting approximately 315,000 enrollees. Six of the failed HMOs were taken over by other HMOs which resulted in no disruption in services to 93,000 members, nor were any of these members exposed to the liabilities of the failed HMOs.

To the best of our knowledge, continuity of coverage has been arranged for the remaining 222,000 members of the other 17 failed HMOs. This was accomplished through a combination of alternative indemnity health insurance programs offered in the employer group, coverage by other HMOs in the service area, and coverage through indemnity insurance programs for individual enrollees.

We are aware of only three situations where members of the failed HMOs were billed for unpaid provider claims. The total members in these three HMOs were 66,000. At this time, it is our understanding that the claims filed against the members (the actual number of claims and members involved is not known) have been or are being settled by the receiver from the assets of the liquidated HMOs and that the members have not or will not be held legally liable for the claims.

Even though the liquidation proceedings will protect members from personal responsibility for the unpaid claims, OHMO recognizes the trauma that these members are exposed to prior to final settlement by the receiver. To prevent members from experiencing this trauma in the future, OHMO is aggressively implementing the recent amendment to the HMO Act, Section 1301(c)(8) requiring each HMO to have adequate arrangements to protect its members from incurring liability for payment of unpaid claims. OHMO strongly supports the efforts of the National Association of Insurance Commissioners (NAIC) to strengthen the requirements of state laws for insolvency protection. OHMO is adapting the NAIC's proposed reserve requirements as one arrangement HMOs may have to satisfy the Federal requirement under 1301(c)(8).

HEALTH BLOCK GRANTS ADMINISTRATION

Question: For fiscal year 1983, the Administration proposes to place the responsibility for two of the health block grants -- preventive and alcohol, drug abuse and mental health -- within the Office of the Assistant Secretary for Health (OASH). The Centers for Disease Control (CDC) now administers the preventive block and the Alcohol Drug Abuse and Mental Health Administration (ADAMHA) administers the block relating to its area.

What is the reason for putting the administration of these blocks into OASH? Is OASH equipped and staffed to run them?

Answer: Consolidating the block grants a single organization will serve to streamline federal administrative functions through various economies of scale and will simplify State administrative functions by providing a single PHS office contact regarding all PHS block grants. Both of the block grants will have completed their transition period by 1983 and it is appropriate to request funding for them in a single agency. The 1983 request includes 40 positions and $2.0 million for staff to administer these grants. Employees from CDC and ADAMHA will be transferred to OASH to provide the program expertise required for the administration of these programs.

Question: How does OASH plan to evaluate the performance of State administration of the block grants?

Answer: The underlying concept of the Department's block grants is that state governments, not the federal government, are now accountable for the achievement of specific programmatic objectives associated with the block grants. Therefore, neither Department nor OASH intend to evaluate the relative performance of the States in administering the block grants.

Question: Why were these two particular block grants proposed for inclusion in OASH, while the Maternal and Child Block and the Primary Care Block were not?

Answer: We consider the first year of funding for each block grant to be a transitional year when it is appropriate that a block grant be administered and budgeted in the agency responsible for the categorical programs being consolidated into the block grant. This provides for a smoother transition, facilitates technical assistance, and maintains program continuity between State and Federal officials. Thus, in fiscal year 1982 the Prevention and ADAMHA Block Grants are currently in their first year and are being administered by CDC and ADAMHA. Similarly, fiscal year 1983 will be the first year of funding for the Primary Care Block Grant and also for the Maternal and Child Health Block Grant after incorporating the Women and Infant Care program from the Department of Agriculture. Accordingly, in fiscal year 1983 these two block grants will be administered and budgeted in the Health Services Administration.

Question: In centralizing the administration of these block grants in OASH, it would appear that the expertise and knowledge of the CDC and ADAMHA staffs would be lost in the process. What steps do you propose to make certain the staff expertise follows the blocks if they are shifted?

Answer: The 1983 request includes 40 positions and $2.0 million for support staff for these block grants. We plan to use these positions to employ or transfer staff from CDC and ADAMHA to provide the program expertise necessary for the administration of these grants.

Question: How much money will this save over current decentralized administration?

Answer: The primary benefits of this proposal are to improve federal administrative functions regarding the grants and to simplify State administrative functions by providing a single PHS contact point. Although savings through this more efficient approach are expected, at this time no estimate of the amounts involved has been developed.

Question: We have received some complaints from States that overhead expenditures of State governments are cutting into services. What are you doing to ensure that administrative expenses of the States are held to a minimum so that funds for providers and services are not cut?

Answer: The Omnibus Budget Reconciliation Act of 1981 allowed the States to use up to 10 percent of the block grant allocation for State administrative costs for the ADAMHA Block and the Preventive Health Block Grants. The Primary Care Block Grant does not allow use of block grant funds for State administrative costs. The Maternal and Child Health Block contains no statutory limitation on the use of grant funds to pay for State administrative costs.

The Department's regulations for the block grants have removed many of the former requirements which would have led to higher overhead expenditures. The planning and reporting associated with the block grants are considerably reduced from that of previous programs. The block grants will also be exempt from the usual Departmental and OMB grant administration requirements. The results of these actions should ensure that administrative expenses of the States are held to a minimum.

Question: What estimates can you provide on State expenditures for administering the health block grants?

Answer: The Department does not have a reporting requirement for the States to provide data on State expenditures for block grant administration.

Question: How do you plan to monitor the requirements of the health block grants that States spend specified percentages for certain activities or award grants to certain entities funded under the categorical programs consolidated in the blocks?

Answer: We will review the intended use of funds reports submitted by each State to ensure that planned expenditures are consistent with statutory requirements. End of year independent audit reports will also be reviewed to ensure that State spending is consistent with State plans and statutory requirements.

Question: How many States have submitted applications for planning grants authorized for fiscal year 1982 to assist them in preparing to assume responsibility for the Primary Care Block Grants, not effective until fiscal 1983?

Answer: To date, 24 States have submitted applications for Primary Care Planning Grants and we anticipate that at least another 14 States will submit applications during current Fiscal Year 1982.

Question: What percentage of the Department's employees previously involved in administering categorical health programs have been transferred to the administration of the health block grant programs?

Answer: In Fiscal Year 1983 we are requesting a total of 80 positions for administration of the four PHS block grants. This represents approximately 5.4 percent of the total number of positions formerly administering the categorical programs consolidated into the block grants.

Question: How many States have transferred funds from the Prevention and Alcohol, Drug Abuse and Mental Health Block Grants to other block grants? How much has been transferred and to which blocks?

Answer: Two States, Georgia and Louisiana have transferred funds from the ADAMHA Block Grant to the Maternal and Child Health Block Grant. Four States, Alaska, Georgia, Louisiana and New Hampshire have transferred funds from the Prevention Block Grant to the Maternal and Child Health Block Grant. All transfers amounted to three percent of either the Prevention or ADAMHA Block except for the New Hampshire transfer from the Prevention Block Grant which was seven percent of that grant.

BLOCK GRANT AWARDS TO INDIAN TRIBES

Question: How many Indian tribes have received direct funding under the Prevention and Alcohol, and Drug Abuse and Mental Health Block Grants?

- What is the average size of the grant award provided to these tribes?

- When were grant awards made to eligible tribes?

Answer: At this time, we expect that two tribes will receive direct funding for the Preventive Health Block and eight tribes will receive direct funding for the ADAMHA Block Grant. The table below summarizes information on these tribal block grants.

Name of Tribe/State	Provisional Award Dollars	Award Date
PREVENTION BLOCK GRANT		
1. Kickapoo Tribe - Kansas	$ 25,749	March 1, 1982
2. Santee Sioux - Nebraska	$ 25,749	March 1, 1982
ADAMHA BLOCK GRANT		
1. Phoenix Service Unit Indian Health Advisory Board - Arizona	$ 94,000	March 8, 1982
2. Tule River Indian Health Center - California	$ 88,000	
3. MI-PI-SHO Development Corp. - California	$ 39,000	
4. Red Lake Drug Program - Minnesota	$ 90,000	March 8, 1982

Name of Tribe/State	Provisional Award Dollars	Award Date
5. Confederated Salish & Kootenai Tribe - Montana	$ 80,000	
6. Devils Lake Sioux Tribal Council - South Dakota	$ 61,000	March 8, 1982
7. Oglala Sioux Tribal	$157,000	March 8, 1982
8. Confederated Tribes of the Chehalis - Washington	$ 67,000	March 8, 1982

SUBCOMMITTEE RECESS

Senator SPECTER. The hearing is recessed. The subcommittee will recess until Tuesday morning, March 2, and will meet in this room at 9:30 a.m. to discuss appropriation requests for the Center for Disease Control.

Dr. BRANDT. Thank you, sir.

[Whereupon, at 11 a.m., Friday, February 26, the subcommittee was recessed, to reconvene at 9:30 a.m., March 2.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

MONDAY, MARCH 8, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 9:33 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Harrison H. Schmitt (chairman) presiding.

Present: Senator Schmitt.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF CAROLYNE K. DAVIS, ADMINISTRATOR

ACCOMPANIED BY:

- PATRICE H. FEINSTEIN, ASSOCIATE ADMINISTRATOR FOR POLICY
- FRANK DERVILLE, ACTING DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT
- ANTHONY ITTEILAG, DEPUTY ASSISTANT SECRETARY, BUDGET, DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. Good morning. The hearing will come to order.

This morning the subcommittee will hear testimony from Dr. Carolyne Davis, the Administrator of the Health Care Financing Administration.

The HCFA budget totals some $72 billion, as proposed, of which a major portion is for the very important medicare trust fund.

The subcommittee's jurisdiction extends to about $33 billion of the HCFA budget. It includes funding for the medicaid program, one of the so-called entitlements we hear so much about these days, which this subcommittee has been examining for quite a number of months.

As I am sure you know, the subcommittee has been most concerned about the rising cost of medicaid and other entitlement programs which come under the umbrella jurisdiction that we have. These are now consuming more than two-thirds of this particular bill before the committee.

We must begin to reduce the cost of the entitlements if we are to have enough left over to adequately fund important discretionary programs in health, education, labor, and other areas, which in turn in the long run will help to reduce demand for entitlements.

Unless we are able to gain some control, any ideas about balancing the Federal budget in the foreseeable future are just so many pipedreams.

Dr. Davis, I look forward to hearing your testimony on these matters.

If you would introduce your colleagues and proceed with your summary statement, we then can go to questions.

INTRODUCTION OF ASSOCIATES

Dr. DAVIS. Yes, I would be happy to.

On my left is Mr. Frank Derville, who is the Acting Director of the Office of Financial Management; on my right is Patrice Feinstein, who is the Associate Administrator for Policy; and to her right is Mr. Tony Itteilag, who is the Deputy Assistant Secretary for Budget from the Department of Health and Human Services.

Let me briefly summarize my prepared statement.

My statement addresses the fiscal year 1982 supplemental request, so I will move directly to the fiscal year 1983 budget request. As you indicated, it is $72.4 billion. That is an increase of $5 billion or 7.4 percent over fiscal year 1982.

Our appropriations request is $32.7 billion, with $856 million to be transferred from the medicare trust funds. The request for the medicaid program is $17 billion. Both the fiscal years 1982 and 1983 budget requests for this activity assumes passage of the administration's legislative proposals.

For payments to the health care trust funds, our fiscal year 1983 request is $15.6 billion, an increase of $1.2 billion over the level that was authorized under the fiscal year 1982 continuing resolution.

In our program management area we are requesting $945 million. That is $89 million in budget authority and $856 million to be transferred from the trust funds for several activities, which I will briefly highlight.

The professional standards review organizations has a request for $25 million, and this reflects our continued commitment to phase out the program. We are proposing to fund half of the 130 PSRO's that are mandated for funding in fiscal year 1982 by the 1981 Omnibus Budget Reconciliation Act. We are also proposing to reduce the degree of Federal support to the remaining PSRO's based on the expectation that the most effective ones can obtain private sector funding. Our proposed legislation would eliminate Federal support, effective July 1, 1982.

We have in the research area a request for $30 million. This is substantially the same as fiscal year 1982. We have reallocated our resources in order to meet congressional mandated studies and we will continue only those projects that will promote cost savings or management improvement. We have earmarked $5 million of our total research budget to be devoted to studies that will focus on increased competition in the health care delivery system.

Our request for medicare contractors is $704 million, which is the same level as provided under the fiscal year 1982 continuing resolution. We expect to reform and streamline the contractor operations in order to continue to achieve both short- and long-term efficiencies and live within the budget. We are also working now at developing a plan to have the contractors increase their utilization review activities within that budget level.

For State certification, we have a request for $51 million. That is consistent with our goal to reduce the administrative burden on providers with satisfactory records, while focusing our surveys on the facilities that have chronic deficiencies.

The request includes an increase of $2.9 million for initial surveys of approximately 1,200 new medicare facilities and $4 million for the State cost-of-living increases. These increases are offset by a reduction of $8.8 million from less frequent surveys of the good performers as well as continuing management improvements.

We are proposing to eliminate the end-stage renal disease networks effective July of this year. Pending the elimination of this activity, we are requesting funding of $5 million through the program management account.

We have a request for $182 million, nearly $1 million, or 1 percent, below the revised estimate for fiscal year 1982 in administrative costs, and this assumes a reduction of about 730 authorized permanent positions.

I would like to point out that this request was developed before the President's decision to propose to federalize medicaid. We are currently examining how such a policy change would impact on our staffing needs and we will return to this committee if our request does require revision in light of the developments in that proposal.

That completes the highlights of my statement, Mr. Chairman. We would be happy to answer any of your questions.

MEDICAID COPAYMENTS

Senator SCHMITT. Thank you very much, Dr. Davis.

As I am sure you know, this subcommittee is extremely concerned about the escalating costs of the entitlement programs. For a variety of reasons they seem to be totally out of control, and anyone who thinks that there is any other basic reason why it is very difficult to find balanced budgets in our future, it is because of these open-ended entitlements programs. I don't know of anyone on this committee that doesn't feel that for most, if not all, of these programs there is a basic core need, safety net, if you will, for those who because of age or disability or other handicap, or for temporary displacement due to loss of employment, over which they have no control, that there isn't a need for that safety net. Our program, of course, has been that people inadvertently or advertently have become entangled in the edges of the safety net and need to be encouraged and trained as appropriate to move out into the private sector and away from being a burden on those who truly need the services.

The administration has suggested a number of reforms in the medicaid program, many of which are considered quite controversial.

Could you describe briefly what these reforms are? Explain them to the subcommittee?

Dr. DAVIS. Yes; I would be happy to.

First, we are proposing that the States be required to impose a nominal copayment on all medicaid beneficiaries for hospital, physician, clinic, and outpatient department services. This would save $329 million in 1983.

Senator SCHMITT. What do you mean by copayments?

Dr. DAVIS. A nominal copayment would be $1 or $1.50 per utilization that the recipient would be required to pay, and then the medicaid program would pick up the rest of the reimbursement.

Senator SCHMITT. That would be independent of ability to pay other costs? That would just be a bottom, minimum payment that each individual receiving the service would pay on that service?

Dr. DAVIS. That is correct. We believe that all of the payments should be minimal. A number of States have already asked us for the option to impose copayments on some of their services. Particularly they are interested in this in relationship to prescription drugs, vision and dental services, and emergency room services. There has been a huge increase in utilization of emergency rooms, some of which we believe is inappropriate. There is a feeling that we can decrease that utilization by imposing nominal copayments.

I would like to point out that a copayment of $1 is quite a nominal sum. It represents not much more than you would pay for a package of cigarettes, and I think it is a more prudent use of resources to spend $1 for health care rather than for something like cigarettes.

Would you like me to continue with the rest of the proposals?

MEDICAID PROPOSALS

Senator SCHMITT. Yes, please.

Dr. DAVIS. The next proposal would be to reduce the Federal match by 3 percent for optional services to the categorically eligible and for all services to the medically needy. That is calculated to have savings in 1982 of $134 million and approximately $600 million in 1983.

We propose to reduce the Federal match for family planning services under medicaid from the current 90-percent level to each State's Federal medical assistance percentage, with a savings of $14 million in 1982 and $55 million in 1983.

We also propose to eliminate the Federal medicaid match for the medicare part B premium payments which States make on behalf of their recipients, which would accrue $45 million in savings in 1982 and $203 million in 1983.

I might point out that all of the 1982 savings are based on the assumption that the legislation will be passed and implemented by July 1, 1982.

We have a proposal to clarify through our medicaid regulations the circumtances in which adult children are financially responsible for long-term care costs of their parents. This would have savings of $29 million in 1982 and $35 million in 1983.

We would also propose to allow the States to impose liens on the property of the medicaid recipient in the long-term care facilities. The States, however, could only recover the lien after the individual has died, his/her spouse has died, and all their children have reached the age of 21. This would have a significant savings of $183 million in 1983.

We are proposing to reduce the extension of the medicaid eligibility for people who are dropped from the AFDC rolls from 4 months to 30 days. That carries with it approximately $17 million in 1982 savings and $75 million in 1983.

We are proposing to establish a single new block grant for the States to use in meeting the administrative costs of their AFDC and medicaid programs at 95 percent of the fiscal year 1982 level of funding, for a savings of $218 million in 1983.

There is a proposal to reduce from 75 to 50 percent the level of Federal reimbursement for training and compensation of skilled professional medical personnel and their supporting staff who are involved in surveying and certification of long-term care facilities. This would yield a savings of $9 million in 1982 and approximately $10 million in 1983.

We are proposing to phase out the Federal financial participation for erroneous medicaid expenditures by a gradual reduction in the error rate tolerance until we reach a zero-percent error rate in 1986, for $59 million savings in 1983.

We are also reflecting in our proposals the impact of AFDC and SSI caseload reductions.

Senator SCHMITT. Did you mention the transfer of funds for medicaid administrative costs to a consolidated welfare administrative fund in your statement?

Dr. DAVIS. The State block grant? Yes, sir.

Senator SCHMITT. Savings of $1 billion? That's what your statement says.

Dr. DAVIS. We have an actual savings in our budget of $218 million, because the other component, I believe, is passed to the AFDC component part of the budget.

Senator SCHMITT. So that is an error in your statement?

Dr. DAVIS. No; let me check that.

Senator SCHMITT. Well, you are saying that the total budgetary savings of the creation of a consolidated welfare administrative fund is $1 billion, but the savings to medicaid is $218 million in 1983?

Mr. DERVILLE. Of the $1 billion savings, Senator, $218 million is a savings to both medicaid and the Federal Government since we will be limiting reimbursement for administrative costs to 95 percent of the 1982 level. The remaining $810 million is a medicaid savings only and results from the transfer of administrative costs out of the medicaid appropriation and into the block grant.

IMPACT OF LITIGATION THREAT ON PROVIDER BEHAVIOR

Senator SCHMITT. Well, that is not clear in your statement. I think this clarifies it.

Is it the opinion of the administration that much of the cost, or a significant amount of the cost that medicaid pays results from hospitals and physicians recommending and undertaking services that one might call optional or maybe even one might call covering your rear because of the threat of litigation?

Dr. DAVIS. We do know that for medicaid 26 percent of the total budget is going for in-patient hospital services; 42 percent for long-term care. Long-term care is the largest part of the medicaid budget and it is growing yearly.

To answer your question relative to the physician service component——

Senator SCHMITT. Well, I am talking about both hospitals and physicians, that because of their concern over litigation, potential litigation, if they have not done enough, that at least would be the contention under litigation, that then they err on the side of doing too much in order to avoid as many such problems as they can. Do you think that is a significant problem in the hospital and for the physician?

Dr. DAVIS. I think that might be a small part of it, but I believe the largest part is unnecessary utilization itself in terms of the number of days and the number of tests that are utilized.

Senator SCHMITT. You don't think that one reason people are brought into emergency services, one reason that there are unnecessary lab tests, you don't think that that is a significant part of medicaid costs?

Dr. DAVIS. I am certain that does have something to do with it. Having been a health care worker myself, I do know that there is a tendency at times to order some extra tests to be certain that one is covered from liability. But what the extent of that is versus just good medical practice, I don't believe that we have data from our research to make a judgment.

Senator SCHMITT. You feel there is no way to find out? Or at least any commonsense way in which the hospital and physician could be protected against litigation of that nature so that we get just the tests that are reasonably useful in serving the patient other than those that are useful only in protecting against future litigation?

Dr. DAVIS. One of the things we are trying to encourage this year, Senator, is a rebirth of the voluntary effort. This time, the American Hospital Association is working very closely with the American Medical Association in looking at utilization review activities, encouraging development of a more cost-effective awareness at the local levels. To the degree that effort is successful, I believe that will help to curb some of those problems.

Senator SCHMITT. But it doesn't change the threat of litigation.

Dr. DAVIS. No, sir, it doesn't. But I believe that if physicians become more aware of the cost of the individual tests, then we will see a change in some of their ordering practices.

Senator SCHMITT. I think you are talking about apples and oranges, Doctor. That may well be helpful to the physician to be more aware, but if the physician feels, or the hospital feels, or both, that a test should be run in case there is some future litigation, they are probably going to run that test.

Dr. DAVIS. Senator, let me explain. When I was at the University of Michigan, I chaired our hospital cost containment committee. We worked very closely with the chief of clinical affairs. This committee looked at a number of areas where we could cut back and we targeted on some of the laboratory tests that were done and some specific drugs that were ordered. Once the physicians were made aware of the costs of some of these tests and drugs, it was a simple matter of their making a choice as to whether a similar test or a similar drug at a lower cost could be used effectively. Granted it was still their judgment, but I think that awareness did give us a significant savings, and that is what I was addressing.

Senator SCHMITT. How are we going to insure that physicians and hospitals all over the country are aware enough so that the cost of these optional services or these tests goes down? Just by talking about it? Is there anything specific that can be done in legislation?

Dr. DAVIS. Well, I think talking about it certainly does enhance the voluntary efforts. We also have a proposal that will address the utilization problem utilizing our own medicare contractors.

I know that the Department has recently encouraged a number of the medical schools to look at ways of developing some parts of the medical school curriculum to look at the whole economic area, and particularly to develop cost-conscious behavior patterns. They would include such things as grand rounds that relate to the cost of clinical care decisions. So it is a several-pronged effort to make physicians and all health care workers more aware of costs.

COMPETITION AND HEALTH CARE COSTS

Ms. FEINSTEIN. May I say something, Mr. Chairman?

Senator SCHMITT. Yes, Ms. Feinstein.

Ms. FEINSTEIN. I think part of our efforts in this area are also aimed at trying to make the consumer a more cost-conscious purchaser of health care services. Both our competition legislation which changes some of the cost-sharing arrangements under medicare, and some of our copayment proposals under medicaid are designed, we believe, to help curb some of that unnecessary utilization, to make the consumer say, "Do I really need this test?"

Senator SCHMITT. Well, you know we have a tendency to think of the consumer of medical services the same as the consumer of bubble gum or something like where you try to get the best deal you can for the most bubbles. Unfortunately, the consumer of medical services more often than not is not thinking about those kinds of things when they need medical services. That is one of the fundamental differences between a competitive health care system and a competitive any other kind of system, bubble gum or otherwise. I am not sure that a lot of jawboning is going to do that. When a person is sick they want everything they possibly can to get unsick and they are really not thinking about costs. Nor are their parents or their family thinking about costs at that time. They are thinking about saving a life or making that life more comfortable, prolonging that life. They are not thinking about costs. We are a compassionate people. Human beings generally are compassionate, given half a chance. So cost is usually the farthest thing from their mind at the instant that they need the service. That is why I think we have to build into the system ways in which those costs can be minimized, recognizing that a truly competitive health care system is very, very difficult to implement.

Ms. FEINSTEIN. I certainly agree with you. I would just say that in the current way we do things there is no incentive whatsoever to say, "What does that cost?" The preponderance of first-dollar coverage, if you will, makes that choice effectively a no choice.

Senator SCHMITT. I agree with you. But I hear an awful lot of rhetoric saying we're going to make medical services competitive in the free enterprise system like everything else, and I think we have to recognize it isn't like everything else. That doesn't mean there can't be some competitive forces, but it is not ever going to be like everything else in that system.

Was it at all considered that there might be a way to underwrite potential litigation for tests not performed in order to give the physician an incentive to look at only the tests that in his or her best judgment should be performed for a particular case?

Dr. DAVIS. We did not consider that.

Senator SCHMITT. Could you make a brief consideration of that and provide the committee with your thoughts on that?

Dr. DAVIS. We would be happy to.

[The information follows:]

MALPRACTICE COSTS

Question. It would appear that many optional services and tests are furnished by hospitals and physicians due to the fear of potential malpractice suits. Have you ever considered the possibility of underwriting litigation costs to help stem unnecessary utilization of these services?

Answer. The costs that hospitals and physicians incur for malpractice are already reimbursable under HCFA's programs.

For example, physicians may consider their malpractice and other overhead costs when setting their customary charges or deciding whether to accept medicaid payment levels.

Nearly all States use the medicare principles of reimbursement for determining medicaid payments to hospitals. Under these principles, the cost of malpractice insurance is reimbursed by HCFA according to the dollar level of claims settled in favor of medicare or medicaid patients compared to other patients. Although malpractice insurance premiums usually cover litigation costs and claims settlement, the hospital may have additional claims for deductible, coinsurance, and settlements in excess of insurance coverage or for litigation expenses paid directly. The hospital receives full program reimbursement for such allowable uninsured costs and related direct costs incurred on behalf of program beneficiaries.

IMPACT OF MEDICARE PROPOSALS ON BENEFICIARIES

Senator SCHMITT. Now with respect to medicare, that is a more difficult area because it deals with the elderly who more often than not are on fixed or limited incomes. Do you think that we really can do much to reform medicare without significantly impacting on the ability of the elderly to receive necessary medical services? This is probably in the long run one of the most critical areas, because our elderly population is increasing at such a rapid rate.

Dr. DAVIS. Yes, Senator. We think that the proposals that we developed this year reflect very conscious decisions to try to make the majority of our reduction in the growth rate in both the hospital area and in the physician reimbursement area. We picked those two areas in addition to identifying some areas that were what we considered to be inappropriate subsidies of the program.

Senator SCHMITT. Is there an inappropriate subsidy for an elderly person on a fixed income barely making their daily necessities and then faced with a medical problem?

Dr. DAVIS. No; when I spoke of an inappropriate subsidy, Senator, I was thinking in terms of the proposal that we have to eliminate the private room subsidy, where we found that we have the potential for paying twice for the private room because of the way in which we currently do our calculations. We consider that an inappropriate subsidy.

Likewise, we have a proposal for the working aged, to ask employers to pick up the cost of the health insurance and, therefore, the first-dollar coverage for the aged 65 to 69 who are working. Currently employers have the benefit of a subsidy because of a better experience rating of their employee health plans because of the first-dollar medicare coverage of their aged employees.

Those kinds of things are what we considered inappropriate subsidy areas.

Senator SCHMITT. But in terms of having access to health care, the cost of that initial access, you would not expect it to change for those elderly who would be unable to pay an increase in cost at this time?

Dr. DAVIS. At this time with the exception of the proposals to reduce the radiology and pathology payments to 80 percent of reasonable charges and to index the part B deductible to the CPI, we don't expect that our legislative program would impact significantly on medicare beneficiaries.

Senator SCHMITT. Which CPI?

Dr. DAVIS. The Consumer Price Index.

Senator SCHMITT. But not modified for the cost of daily services and sustenance?

Dr. DAVIS. No.

Senator SCHMITT. The existing CPI includes a calculation for interest payments which the elderly tend not to have to bear at the same level as the rest of the population. You would not modify that?

Dr. DAVIS. No, we would not. Our assumption on this one, Senator, is that since the part B premium is indexed and social security payments are indexed, that it is only appropriate to index the part B deductible.

INDEXED MEDICARE PART B DEDUCTIBLE

Senator SCHMITT. I understand there is a proposal to index the medicare part B deductible, which does increase out-of-pocket costs. It would increase annually from the present $75 deductible. Is that correct?

Dr. DAVIS. That is what I was referring to, Senator.

Senator SCHMITT. Would that increase out-of-pocket costs across the board?

Dr. DAVIS. Yes; let me point out that it has remained at the $60 level since 1972, despite the fact that there has been an over 250-percent increase in the program reimbursements for that Part B during that same interval of time. We believe that unless we index the deductible, its value as a deterrent against unnecessary utilization will erode. Also without indexing we would have to come back to Congress yearly to ask for an increase to keep pace with inflation.

Senator SCHMITT. Would you index it to CPI?

Dr. DAVIS. Yes; that is the proposal.

Senator SCHMITT. Why couldn't we index it to the real inflation rate experienced by that particular group of beneficiaries?

Dr. DAVIS. We indexed it to the CPI because these individuals are getting a social security increase based on the CPI.

Senator SCHMITT. Maybe we ought to index social security increases to the real CPI, not the one that we calculate.

Mr. ITTEILAG. The problem, Senator, is one of deciding what the "real CPI" is. In the current scheme of things, because we couldn't in the Department do that on our own, it would be difficult and administratively complex to have a separate CPI just for this purpose.

Dr. DAVIS. Our estimation, Senator, is that by using the CPI the average beneficiary would be paying $7 a year more than they do now.

Senator SCHMITT. But averages are tough, because down at the end of the scale of the very low-income elderly who have a medical problem that cost tends to—even $7—be much more than that even though the national average would be $7.

Dr. DAVIS. Senator, let me clarify the issue, since we are talking about a change in the deductible, not coinsurance. Under this proposal, every beneficiary who receives reimbursement from the program will have increased out of pocket expense of $7 for the year.

Senator SCHMITT. What if we use CPI but went to some percentage of CPI for this particular area? Or even for social security? Or maybe some percentage of CPI calculated over the last quarter or the last half year to get a more realistic measure of what CPI is?

Mr. ITTEILAG. Senator, I would think that in this particular situation the primary determinant of what would happen is what is happening to the social security payment itself. In other words, if the social security adjustment were changed to a different formula or to a percentage of the current CPI, then I think this proposal would be revised to logically follow along with that on the same basis. The primary emphasis ought to be on consideration of the percentage of the social security increase.

Senator SCHMITT. Well, with the only exception being that—I am arguing against myself a little bit—medical cost inflation is far greater than CPI.

Mr. ITTEILAG. That is true, Senator. In this particular proposal there is an offsetting benefit increase in medicaid for those people who are dually eligible, so that those who are the most needy would in effect end up not paying this increase if our proposal were accepted as it is currently being considered.

Senator SCHMITT. Could you detail that a little bit for our record, that particular interplay between the two systems?

Mr. ITTEILAG. I would be happy to, Senator.

[The information follows:]

RELATIONSHIP BETWEEN MEDICAID AND MEDICARE

States have the option of buying part B coverage for those medicaid recipients who are also eligible for medicare. Currently, 47 States have part B buy-in agreements. Under the part B buy-in agreement, medicaid will pay the deductible and the premium costs—States may also pay the coinsurance—associated with part B coverage. Therefore, low-income elderly individuals who are eligible for both medicare—part B—and medicaid will not be affected by the proposed increase in the deductible.

The number of medicaid recipients who are eligible for SMI and who use SMI covered services represents approximately 10 percent of the SMI enrollee population, or 2.7 million persons.

The Federal share of the additional medicaid cost is indicated below:

[In millions of dollars]

	Fiscal year—				
	1983	1984	1985	1986	1987
Medicaid cost	8	15	20	25	30

MEDICAID—HOME AND COMMUNITY SERVICES

Senator SCHMITT. Thank you.

Have you considered any other alternatives for reducing medicaid costs that were not included in the budget that you want to share with the committee? Or even if you don't want to share them. [Laughter.]

Ms. FEINSTEIN. I would say that as we watch the implementation of some of the waivers brought about by the 1981 Reconciliation Act we may see some savings accrue to the medicaid program which have not evidenced themselves too much so far.

Senator SCHMITT. What type of waivers?

Ms. FEINSTEIN. Those that concentrate in the area of home and community services, lock-in of beneficiary choices, some case management waivers, hospital reimbursement changes. Some States have begun moving in those directions and others, quite frankly, have not yet.

Senator SCHMITT. Is there any way that we can build new incentives in for States to exercise better control over physician fees, hospital fees?

Dr. DAVIS. I think a number of States are addressing that now. The 1981 Reconciliation Act clearly did give them much more flexibility and more incentives in this area. I do know that some of the States have addressed the area of putting a lid on physician fees.

Senator SCHMITT. Do you think the ultimate incentive is to reduce the availability of reimbursement?

Dr. DAVIS. Well, I think putting a lid on the growth of reimbursement is certainly one possibility. Clearly, another incentive in the medicaid area is to look at establishing some form of alternative to long-term care since that is the fastest growing portion of the medicaid budget, currently consuming almost half of it. Some 13 States have already asked us for waivers in the area of home and community services.

Senator SCHMITT. Could you provide us with a list of those States?

Dr. DAVIS. We certainly will.

[The information follows:]

COMMUNITY-BASED WAIVERS

To date, 13 States have requested waivers under section 1915(c) of the act to provide home and community-based services to individuals who would otherwise require institutional care. These States are: Oregon, Louisiana, Montana, Florida, California, Georgia, Tennessee, Minnesota, Vermont, Kansas, Missouri, Rhode Island, and Nevada. Florida and California each requested two waivers, and Kansas requested three. Approvals have been granted to Oregon, Louisiana, and Montana.

Senator SCHMITT. You really feel that there is a strong movement now toward increased utilization of home care for long-term care?

Dr. DAVIS. I think that there is a strong movement toward looking at a variety of alternatives to institutionalization. These include the use of home health services, home and community services, personal care services, or some mix of services that would keep the individual from having to be institutionalized. It is our experience that the States are very interested in these alternatives and if they can be proven to be cost-effective, I feel sure that we'll see movement in this area.

There has been an average annual increase in long-term care of something like 18.7 percent from 1973 to 1981. So it truly is one of the fastest growing components in the medicaid budget.

We also believe that the 3-percent reduction in optional services will provide some incentives in this area, too, since the intermediate care facility benefit is an optional service.

SWING BED IMPLEMENTATION

Senator SCHMITT. In that regard, in rural parts of the country, and maybe in others, the swing bed concept for hospitals has a very attractive image, and the Reconciliation Act of 1980 authorized the Secretary to allow hospitals to set aside swing bed hospitals. This would allow hospitals, of course, to use certain beds either as acute care beds or long-term care beds, depending on the current situation and need of such services in those communities. Ten Senators, including myself, wrote you a letter last October urging you to rapidly implement a flexible set of regulations to use the swing bed proposal. In February we received a very vague response.

Why has HCFA not issued regulations to allow implementation of this program?

Ms. FEINSTEIN. Senator, those regulations are now through the HCFA clearance process. It was a rather difficult regulation to put together. Although we were very eager to move it through the system, we had a number of different opinions from the outside groups as to how one counted those beds and as to which conditions of participation should apply. In regard to the latter issue, the question was whether they were in effect long-term care facilities and so ought to come in under the conditions of participation applied in the long-term care area, or whether they were really hospitals with the distinct part. Quite frankly, we spent a number of months wrestling with those issues. I believe we have resolved them now.

Senator SCHMITT. When would we expect to see the final regulations issued?

Ms. FEINSTEIN. They are in departmental clearance. After that it will go to OMB. I would imagine it would be up here within 4 to 6 weeks.

Senator SCHMITT. Is there any way we could get some advance notice of what you are proposing to see if there is going to be any hue and cry up here? Are they going to do what we want to do? You know, everybody out there sort of thinks of it as a fairly simple concept. Obviously it hasn't turned out that way, at least within HCFA.

Ms. FEINSTEIN. I believe you will be pleased with the results.

Mr. ITTEILAG. I would think, Senator, if we discussed it outside the Department with various groups there is absolutely no reason in the world why we couldn't discuss it with your staff as well.

Senator SCHMITT. I had the same thought. If you would do that and provide us for our record at least some general outlines of what you expect the regulations to show.

[The information follows:]

SWING BED REGULATIONS

The regulations will provide small, rural hospitals with the ability to meet fluctuating demands for hospital and long-term care in a cost effective and efficient manner. We are seeking to strike a balance between assuring adequate quality of care for long-term care patients in swing bed hospitals and encouraging maximum participation of the 1,300 potentially eligible hospitals. We believe the regulations will accomplish this objective and that there will be a significant increase in the availability of long-term care beds for Federal program beneficiaries in rural areas.

EFFECT OF COST SHARING ON UTILIZATION

Senator SCHMITT. Do you have any idea on any factual or qualitative or quantitative basis to assume that a beneficiary would forgo a visit to a doctor because of the copayment provision, a visit that might subsequently be a lead to a more expensive, more serious illness in the future?

Dr. DAVIS. On average the medicaid beneficiary has four and one-half physician visits a year and one clinic or outpatient visit per year. So our total copay expenditures under our proposal would be $6 for a physician and $7 for the hospital for the year. There will always be exceptions to the average. But we don't believe that $13 a year will deter necessary utilization.

Senator SCHMITT. But again, I am really concerned about your using averages. From my previous profession as a scientist, they can get you into trouble. The average or mean is not potentially what is going to cause you the biggest expense. At the lower end of the economic scale are those people where a few dollars means most and acts as a deterrent toward seeking hospital care. Certainly my own mother is neither ill nor destitute, but we have an awful hard time getting her to talk to a physician, without that problem, and I hear this is the case in many, many individuals. She's not alone in being reluctant to go to a doctor. Now if you add some extra costs to that, don't you also add an increased reluctance to do that, particularly where every dollar is important, and certainly because of the unfortunate media blitz that we have been exposed to in recent months there is a perception of greater economic doom on the horizon than really is warranted.

Dr. DAVIS. I suspect there is always that possibility. Just as you indicated, averages do not take into consideration the extremes. But as to the dimension of the amount, our presumption again is that if those copayments are kept nominal, and we consider nominal to be in the $1 to $1.50 range, it should act to deter unnecessary utilization but not services that are truly needed.

Senator SCHMITT. But this is a judgment call.

Dr. DAVIS. It is indeed a judgment call.

Senator SCHMITT. It is not supported by any test program or prototype programs that you are aware of. Have any States attempted to imply, or could they have attempted to imply a copayment feature?

Dr. DAVIS. We have a number of requests for waivers relative to copayments from the States.

Senator SCHMITT. But no State has ever done this so that you would have a test case to look at, is that correct?

Dr. DAVIS. California did have a copayment in the early 1970's.

Senator SCHMITT. Do we have any data from that that supports the administration's decision to seek this as a national remedy?

Ms. FEINSTEIN. The California experience, again in a broad generalization, indicated that there were not adverse effects on beneficiaries; that is, they looked at the data, and they curbed what they believed to be unnecessary utilization.

Senator SCHMITT. Did they stop the copayment experiment?

Ms. FEINSTEIN. Yes; it was under a waiver and the waiver ran out.

Senator SCHMITT. They didn't ask to renew it?

Ms. FEINSTEIN. They are back in now asking to renew it.

I would point out that the American Public Welfare Association recently conducted a survey in States specific to this proposal and received 22 responses, 19 of which said they did support it.

Senator SCHMITT. When they computed the savings from this proposal, how much was due to reduced utilization? Or how much from the collection of the fee?

You may want to supply us an analysis of the California study for the record. It would be very helpful, if there has been one or more studies of the California study, to know whether there is any quantitative justification for the administration's proposal.

Ms. FEINSTEIN. I would be happy to.

[The information follows:]

CALIFORNIA COPAYMENT EXPERIMENT

In the California copayment experient, which lasted over a year, approximately 30 percent of the State's medicaid beneficiaries were required to share in paying for prescriptions and visits to health practitioners. Each month, 50 cents for each of the first two prescriptions and $1 for each of the first two visits to health practitioners was required. As a result of the project, utilization rates were reduced up to 15 percent for some groups. Data showed that beneficiaries did not forgo care for problems that they considered serious or for medical conditions judged significant by a physician panel.

We are confident that imposing reasonable cost sharing for certain medicaid services will discourage inappropriate utilization and provide incentives for the use of cost-effective health services, while not deterring beneficiaries from seeking necessary care.

ZERO-ERROR TOLERANCE FOR MEDICAID

Dr. DAVIS. For our own assumptions, when we were calculating our savings we assumed there would be a 2-percent reduction in the utilization of hospitals as a result of the copayment.

Senator SCHMITT. On the zero-error rate tolerance, Dr. Davis, last year Dr. Willging testified that he thought a 3- or 4-percent error rate was a good target to shoot for in the medicaid program. He added, "But there is a point where the administrative expense put in to reducing error rates begins to outweigh the savings in reduced erroneous payments. I hope that we will reduce eligibility error to a 3- to 4-percent level."

The administration is now calling for the States to achieve a zero-error rate by fiscal 1986. I must admit that I am a little bit skeptical of reaching a zero-error rate by any reasonable cost. These tend to be asymptotic curves, if I may dip back into my mathematical training, and the cost of achieving that last 1 or 2 percent can be very, very great, and in fact impossible to achieve. What has happened to refute Willging's analysis that savings may not exceed costs in an effort to reduce error rates below 3 percent?

Dr. DAVIS. We took a look at our recent error rate report from April through September 1980 and found that there were 23 States that were already under 4 percent. I might point out that one State, Minnesota, is at a five-tenths of 1-percent error rate, with others running in the 1- or 2-percent category. I think this is indicative of the fact that with appropriate MMIS systems in place you can detect your eligibility errors early on. Our feeling was that in tight budget times, when every dollar must count, it would be inappropriate for us to pay for reimbursement that is in effect reimbursement in error. As an incentive to the States to continue to be mindful of that error rate, we believe that we should phase in a zero tolerance by 1986.

Senator SCHMITT. When you use the word "zero" you are not talking about an absolute zero-error rate; you are talking about an error rate that approaches zero to the degree that is technically and humanly possible, are you not?

Dr. DAVIS. What we are saying is that we think that that the $1 billion now being spent on eligibility errors would be better reallocated and spent for services to those who do truly need them.

Senator SCHMITT. Doctor, does the Minnesota experience indicate that you can achieve that $1 billion savings at a cost of less than $1 billion nationally?

Dr. DAVIS. I would have to submit for the record exactly what the costs were.

Senator SCHMITT. You will notice that I at least on this subcommittee, and I suspect many others, believe that we ought to base these decisions on experience if experience is out there. I am not afraid of making some commonsense judgments on what I think will work, but it certainly helps to sell your program if you've got some data from that crucible of experience that we have out there in the States.

The California experience concerning copayments, and the Minnesota experience in achieving a very low error rate summarized for the committee would be very helpful for us to reach our own judgments even though we know that these decisions lay, at least at this time, in some other committee. If they do not choose to act, it is my hope that I can get this committee to be willing to act, as they were last year. Maybe we will have more support from the administration and others in acting if the Finance Committee and others cannot get their act together.

Dr. DAVIS. I would like to point out that the $59 million in savings for 1983 is based upon the assumption of a 3-percent error rate.

Senator SCHMITT. You really need to look hard at that, at whether or not you can achieve a zero-error rate at a cost less than what you save, and be careful you don't jump into an insoluble problem.

Have you estimated how much money the swing bed concept may save nationally?

Ms. FEINSTEIN. We will have to submit that for the record. I don't have that before me.

[The information follows:]

SWING BED REGULATIONS

As a result of several offsetting considerations and the limited application of the provision, we believe the current swing bed provision will have negligible impact on HCFA expenditures for long-term care. We believe that the increased program expenditures from previously unmet demand for nursing home beds will be largely offset by a reduction in per diem costs for hospital care in a swing bed facility as well as a reduction in payments for continued hospital stays when no appropriate long-term care bed is available in the area.

Senator SCHMITT. Well, on a hospital-by-hospital basis, at least in New Mexico, it is clear that the hospital administrators believe that it will save them significant money, but I have never seen an analysis of what that may be nationally, or if there are some hidden costs to it in some other way that would offset the advantages that an individual community might gain.

Ms. FEINSTEIN. The decision to move forward with the swing bed in the rural area was born out of a research project that showed it would be effective nationwide.

We have plans in our 1983 research budget to conduct a swing bed evaluation and to begin to look at swing beds in some of the urban areas as well, and if the results are positive I would expect we would be back before this committee and others in a year or so with legislation to move to swing beds in other areas as well.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Senator SCHMITT. With respect to PSRO's, HCFA has once again submitted a budget that calls for a phaseout of the Federal funding of the PSRO program. While the performance of PSRO certainly varies nationwide, there is evidence that certain of these organizations work very effectively to reduce unnecessary utilization of medicare and medicaid services. You indicate that those most effective programs can be financed within the private sector itself. Do you have any offers of such financing in any States? I know New Mexico has had what we believe, and I think most people, not all, think is a very effective, cost-effective PSRO program, but I have never heard of anyone coming forward and saying that they would pick up those costs, even though I may believe with you that they should.

Dr. DAVIS. Yes; we do know from a recent survey that some 50 PSRO's do have outside contract funding. I might add that the New Mexico PSRO does have a small private contract with one of the area firms. So we do recognize that the more efficient ones can contract, not just with private firms but also with States. I believe that the State of New Mexico has contracted with a local New Mexico PSRO.

Senator SCHMITT. But do you feel that the funds are there to make up the loss of Federal funds that also support these PSRO activities?

Dr. DAVIS. We believe for those PSRO's that have proven to be effective and efficient, States or hospitals or private corporations can indeed contract with them.

Senator SCHMITT. Can; but will they?

Dr. DAVIS. Well, I think it will be optional, Senator. We do know that in some States they have, and I do know that a couple of other States have opted to do their own utilization review in another format rather than use the PSRO's. So it will depend on the State's assessment of the effectiveness of a particular PSRO.

Senator SCHMITT. So even though they are cost effective, the administration's feeling is that all ought to be cut off from Federal funds?

Dr. DAVIS. What we have said, Senator, is that we do not believe that we should be supporting the administrative costs of these kinds of activities.

Senator SCHMITT. Even though you save money in the other part of the program?

Dr. DAVIS. Well, I think it's debatable. Our studies don't indicate that there has been any significant cost savings overall as a result of this.

Senator SCHMITT. Not nationwide, because you have got a mixture of ineffective and effective programs, but if you set some criteria to support the effective ones, then there is an incentive for the others to become more effective in order to get those funds. But the net cost to the Government is lessened because of the decreased error rate that the PSRO's provide.

Dr. DAVIS. What we have indicated is that if a State believes that a PSRO is effective then they would fund it out of their own administrative funds. If hospitals want to contract for utilization review because they found it to be an effective tool, they could and it would become part of the hospital's costs which we would then reimburse.

Senator SCHMITT. So you're saying that in capping medicaid you put in the incentive for the States or other organizations to pick up the funding of effective PSRO's in order to be able to live within that cap?

Dr. DAVIS. If they find it effective to do so.

I want to point out that we are proposing legislation that would eliminate the utilization review requirement so that the State wouldn't be bound to have to do a utilization review.

Our PSRO proposal is coupled with another initiative; we would have utilization review done through the medicare contractors since they were in a position to review both the A and the B activities.

REIMBURSEMENT FOR PREVENTIVE SERVICES

Senator SCHMITT. Are there preventive health services under medicaid or medicare at all? Preventive medicine service. I don't like to prevent health.

Dr. DAVIS. The EPSDT program, which is funded under the medicaid program, is one example of a preventive health care program that we do recognize and fund.

Senator SCHMITT. What proportion of medicaid costs are related to preventive medicine?

Dr. DAVIS. I would have to submit that for the record.

[The information follows:]

MEDICAID PREVENTIVE SERVICES

Question. What proportion of medicaid costs are devoted to preventive health? Should we not be doing more in this area?

Answer. States do not report medicaid expenditures by those categories which fall under preventive services. Therefore, we do not know the total costs of such services to the medicaid program.

We believe, however, that strengthened prevention activities can assist us in our efforts to lower health care costs while maintaining or improving the quality of care. States may provide at their option, a variety of diagnostic, screening, and preventive services. Currently, about 22 States provide diagnostic services, 15 provide screening, and 20 provide preventive services under this option.

Other medicaid services with a preventive focus include those provided through the early and periodic screening, diagnosis, and treatment—EPSDT—program for children and community-based services—under a waiver of medicaid requirements—for individuals who would otherwise require institutional care. All States also provide family planning services which may include pertinent health education and counseling. Medicaid recipients may also enroll in health maintenance organizations and similar comprehensive care organizations which place a strong emphasis on preventive services.

Senator SCHMITT. Can you guess? Is it 1 percent? 10 percent? 50 percent? Bigger than a breadbox?

Dr. DAVIS. A small percent.

Senator SCHMITT. Smaller than a breadbox.

Isn't this self-defeating? Shouldn't we be applying more or encouraging more of a proportion of the medicaid budget to be going to preventing disease rather than taking care of it after it has occurred?

Dr. DAVIS. Well, I think that, given our budget situation, it is a difficult time to make that kind of a judgment.

Senator SCHMITT. But it is going to get more difficult unless you start preventing disease.

Dr. DAVIS. I agree. We have a number of initiatives in the research area looking at prevention and prevention demonstrations. The Department has a rather large-scale effort in the whole area of health care and preventing disease. We are not in the position at this point in time, however, of saying that we would pick up on a number of new initiatives that would add new dollars into the budget. It is difficult to judge what services would be cost effective.

Senator SCHMITT. I don't find it very difficult at all. I tell you, if you can prevent disease or cure it absolutely when it occurs you are going to be a lot better off than if all you do is treat disease.

Dr. DAVIS. I couldn't agree with you more.

Senator SCHMITT. That's what everybody says. This budget and every budget I have seen since I have been on this subcommittee and chairman of it tends to deemphasize the prevention of disease.

Dr. DAVIS. It is one of the Secretary's highest priorities, and this will become clearer as he directs the drafting of our legislation. In the areas of HMO's, we are interested in moving our beneficiaries as rapidly as we possibly can into HMO's or HMO-type providers who do emphasize the preventive mode. This does allow us to have a type of cap on spending and it is something we are very much behind. We have had some very positive outcomes in our HMO demonstrations which included a strong emphasis on preventive services.

We have some data that indicate that 20 States do provide for a variety of preventive services in their medicaid programs, and we do, of course, match their expenditures.

EFFECT OF MEDICAID REDUCTIONS ON PREVENTION

Senator SCHMITT. Will the cap that is being proposed, if it is enacted by Congress, tend to reduce the amount of preventive services that States provide? Will they see this as their first line of cuts in order to live within that cap?

Dr. DAVIS. I think it is too soon to tell just yet. It would be a State's judgment as to what is the most effective use of their own resources. The EPSDT program, of course, is mandatory, but the other preventive services are not.

Senator SCHMITT. Did you consider an even greater reduction in the cap but with the exemption from that of preventive services?

Dr. DAVIS. No, sir; we did not.

Senator SCHMITT. So you would have a dual incentive for that kind of activity. Your problem is, of course, that preventive medicine isn't active usually over a year; it's active over many years and it pays off over a longer period of time than most people, certainly State budgets and Federal budgets, are able to focus on, and you have got to be imagining how in the world you are going to encourage these disease prevention activities so that you can see some significant reduction in costs in the future.

You don't have any ideas?

Ms. FEINSTEIN. The medicaid program by and large is up to State discretion as to what they cover and what they don't. The early periodic screening diagnosis and treatment benefit is mandatory, and we are not walking away from that. We believe that if you focus some of the attention on children and catch some of these illnesses that there is a great payoff. Beyond that, we don't have the authority to go in and tell the States you must do this and you must do that.

Senator SCHMITT. You are saying that the early and periodic screening diagnosis and treatment program is required, the States cannot cut that?

Dr. DAVIS. Correct.

Senator SCHMITT. What is the nature of that requirement?

Ms. FEINSTEIN. It is a mandatory service under medicaid. It is not part of the optional services group, and, therefore, it is not subject to a cut in our 1983 proposals.

Senator SCHMITT. That's relative to children; right?

Dr. DAVIS. Yes.

Senator SCHMITT. What about others? Are other preventive medicine activities optional?

Ms. FEINSTEIN. Again, it is very much up to State discretion.

Senator SCHMITT. But from the Federal point of view they are optional?

Ms. FEINSTEIN. Yes.

Senator SCHMITT. Do you think it would be possible to build in an incentive so that those would be the last to be cut by the States rather than the first? Because if I was a State sitting there and knowing that I've got to live from year to year, I would cut the things that do not affect me this year. Even though they may affect me more in the out years, I can't think that far ahead. I'm the State legislature or I'm the Governor and I'm sitting there and my term runs out in 4 years, in 2 years.

Ms. FEINSTEIN. If one looks at the home and community-based services as a mode to prevent institutionalization, we are seeing States move somewhat rapidly into that area. Again, it's up to their own discretion. But I think that it is an example of planning for down the road where they don't want to have these patients institutionalized. I believe States are beginning to realize that perhaps these people can be more appropriately cared for at home and that institutionalization can be prevented.

IMPORTANCE OF PREVENTION

Senator SCHMITT. We may have some more questions for the record.

I am really afraid that unless we find a way to emphasize prevention of disease or the actual cure of disease and injury once it occurs we are on a treadmill to disaster. Whatever cap you put on medicaid, health care costs in this country are going to bankrupt us before social security bankrupts us. No question about that. I have yet to see any way in which you can satisfy the compassion that Americans have for each other, and particularly in families they have for members of their families, with a leveling off and a reduction of health care except for preventing the disease and curing disease and injury when it occurs.

If you have got any other way to do it I would like to hear about it, but I just don't see it. And that is why the NIH is so important; that is why the nutrition programs are so important; meals programs for the elderly are so important. At least they are aimed at prevention in major ways.

Dr. DAVIS. The Secretary's initiatives in terms of the whole Department's position on prevention clearly indicates that he is in agreement with you.

Senator SCHMITT. Well, I know he is, and the Secretary and I have talked many times about this, but I still see the budgets come out with the emphasis on treatment and not on prevention. You've got to emphasize treatment, but there has to be at least some movement toward the relative proportions in the two areas, and I don't see that movement.

Dr. DAVIS. The difficulty comes in trying to define what would be a cost-effective prevention program. I think there are different dimensions to what individuals consider to be preventive services. We will certainly go back and take a look at these.

Senator SCHMITT. How about paying for medicaid by an excise tax on tobacco and alcohol? Is that a good balance?

Dr. DAVIS. I certainly can't speak for the Department on that, as you well know, Senator.

PROGRAM MANAGEMENT SUPPLEMENTAL

Senator SCHMITT. The administration has requested a fiscal year 1982 supplemental of $5,941,000 for personnel costs related to reductions in force within HCFA. This is part of the overall plan to reduce HCFA staff by roughly 25 percent. Given the administration's proposal to federalize medicaid, is this reduction in force still HHS policy?

Dr. DAVIS. The proposal for the second reduction in force of 500 employees is in the 1983 budget and was decided upon prior to the President's initiative in federalizing the medicaid program. As we have clearly indicated in our statement, we believe that as we continue to develop the proposal on the federalization of medicaid, if we find that our resource needs have changed, we would come back to the committee and submit an additional request at that time.

Certainly a reduction of some 25 percent in staff in less than a year does mean a total reorganization of the agency. It is a challenge to any manager to continue to insure the integrity of the programs. We have been working diligently trying to define the functions that we would continue to perform in terms of the program oversight and which functions we would eliminate.

Senator SCHMITT. If we did not provide the supplemental would that mean you couldn't have the reduction in force?

Dr. DAVIS. Well, let me point out that the supplemental is composed of two parts: First, there is $2 million in costs associated with the fiscal year 1982 reduction in force; second, there is about $4 million associated with the fiscal year 1983 reduction in force. If we did not receive funds for the cost of the fiscal year 1982 reduction in force, which is already underway, we would have to resort to separating more individuals in order to meet that shortfall and possibly go into some furloughs. It might be a combination of the two.

We combined the costs of both RIF's into one supplemental request because we had a RIF that was scheduled for April 1 as well as the need to be down an additional 500 positions by very early in 1983 according to the fiscal year 1983 budget.

RECORDKEEPING FOR MEDICAID AND MEDICARE

Senator SCHMITT. What is the status of record keeping and record verification with respect to medicaid and medicare? Are you basically up to date, the Federal involvement in this, to the degree there is Federal involvement? Does the State process all of this and just send you a reimbursement request? I am showing my ignorance now about the details of the process.

Mr. DERVILLE. The details of the process, Senator, in terms of medicaid is that we are required to match State expenditures. The majority of the States are on a drawdown program in terms of the cash; that is, once they send in HCFA form OA 25 which documents their needs for the coming quarter as well as any adjustments from previous quarters we issue a quarterly grant award to them, and with that they are able to go to a Federal Reserve bank and draw down funds.

Senator SCHMITT. The Federal Government, with respect to medicaid, doesn't do any specific processing of records of individual recipients of medicaid?

Dr. DAVIS. No, we do not. We go in and oversight some 3 to 5 percent of the States' claims in any year's time.

Senator SCHMITT. When you do that do you get into the details of the records? Do you actually go through the patient records?

Dr. DAVIS. That is a very technical level of questioning. I will have to submit it to you for the record.

Senator SCHMITT. The reason I ask is because I am aware of significant excess capacity in the processing of FICA records, and I am just wondering whether there is a backlog that needs to be handled by the Federal Government?

Dr. DAVIS. My staff tells me that we do actually go in and do a sample claims review. Again, it is limited.

Senator SCHMITT. That is at a 3- to 5-percent level annually?

Dr. DAVIS. That is right.

Senator SCHMITT. Who does that? Do you contract for it to be done?

Dr. DAVIS. In the medicare program we perform oversight of the contractors; in the medicaid program we perform oversight of the State agency personnel.

Senator SCHMITT. Do you hire temporary employees?

Dr. DAVIS. No, sir; we have our own staff that does do that.

Senator SCHMITT. Do you know what the size of that staff is, that organization? Of the medicaid activity in this country, 3 to 5 percent would be a very large number of records to go through.

Mr. DERVILLE. Senator, we have in each of our regional offices a financial management staff, and one of their jobs or duties is to oversee and perform assessments of each of the States on their program, on their errors, and what have you. I don't have with me what the exact number would be on each of the regional offices. We could submit that if you wish.

Senator SCHMITT. I would appreciate it, please.

Mr. DERVILLE. Yes, sir.

[The information follows:]

MEDICAID REVIEW OF RECORDS

The medicaid quality control—MQC—system is designed to monitor payments made to providers to identify errors and incorrect payments in all areas of the medicaid program, provide reasons for these errors, and produce data which can be used for State and Federal corrective action.

MQC reviews a statistical sample of cases on a 6-month cycle from October to March and April to September each year. States sample 78,000 cases semiannually out of an estimated 9.3 million cases. The Federal Government re-reviews 16,000 of these cases to assure the accuracy of States' findings. There are approximately 114 full-time equivalent positions dedicated to these Federal re-reviews.

The following types of monitoring are conducted during these reviews to determine State error rates:

Eligibility review.—Determines whether the sampled case is, in fact, eligible to receive medicaid benefits during the sample month.

Claims processing review.—Determines if sampled claims were paid in accordance with State requirements.

Third-party liability review.—Since medicaid is by law the last payor of medical expenses, insures that no insurance company or other third party was obligated to pay a portion of the claim paid by medicaid.

A sample of cases reviewed by the State is reviewed by Federal personnel to verify the accuracy of State findings. Final error rates are then calculated using the relationship between original State findings and final Federal findings in the subsample. These error rates are used to determine whether disallowances may be appropriate for any given State.

ADEQUACY OF MEDICARE CONTRACTOR REQUEST

Senator SCHMITT. The committee believes that the performance of the medicare contractors who handle claims for processing for medicare beneficiaries is crucial to the efficient expenditure of Federal health care dollars. In fiscal 1982 medicare contractors received $711 million, down $14 million from the committees' recommendation of $725 million. In fiscal 1983 the administration is requesting $704 million. How can the medicare contractors be expected to process the higher volume of claims with less money?

Dr. DAVIS. Only by streamlining their operations. We believe that they will need to utilize more computerized technology for claims processing and go into such areas as paperless processing of claims.

We have a task force that is now looking at completely redesigning the way in which medicare contractors currently pay their claims.

Senator SCHMITT. Can you cut the budget before that redesign is in place?

Dr. DAVIS. Well, it is a challenge for us to meet this target by the new fiscal year.

Senator SCHMITT. Nobody said it wouldn't be a challenge, right?

When do you expect to implement recommendations that may come out of these studies?

Dr. DAVIS. We have a task force that is working right now, and as they identify new areas that we can streamline or simplify we are implementing them. But the full task will be completed and put in place by the beginning of fiscal year.

Senator SCHMITT. The processing of FICA claims has been undergoing some major modernization efforts. I am familiar of course, with the Albuquerque center where they have had a remarkable increase in efficiency of processing some 45 million pieces of paper annually in one of three offices nationwide. Is your task force examining the procedures by which they have improved their efficiency? Probably by the end of this year they will be able to do in 9 months what had taken them 12 months to do previously.

Dr. DAVIS. There is no doubt that if funds were available we could enhance productivity. In other words, by buying the necessary hardware to enable us to move toward more automated claims processing, we could improve the productivity of the contractors. Unfortunately, we are on a tight budget. In the last couple of years we have been unable to devote as large an amount to productivity enhancement as we would like to do.

Senator SCHMITT. This is an oversimplified statement, but the processing equipment in the data operations center in Albuquerque is going to be idle for 3 months out of the year. Have you looked at the possibility of piggybacking your activities in that?

Dr. DAVIS. No, sir, we have not.

Senator SCHMITT. I am again doing back-of-the-envelope calculations, but it would seem that you could process about 10 million pieces of paper in that 3-month period of time. Again, oversimplifying what their actual workload curve is, but it would be that plus a little bit more.

Dr. DAVIS. It is something we could look into.

Senator SCHMITT. Who should my staff contact?

Dr. DAVIS. I think Mr. Kappert of my staff here would be happy to talk to your staff about that possibility.

One of our problems, of course, would be to insure an even workflow all year long.

EFFORTS TO REDUCE MEDICAID ERROR RATES

Senator SCHMITT. Well, it would not be in this case, but my point is, if you are not getting things processed, then when you process them is relatively incidental if you get them processed.

What initiatives have you undertaken since coming to this job, Dr. Davis, to try to reduce the error rates in the medicaid program, other than your studies? Anything specific that we can point to?

Dr. DAVIS. The Department has an interdepartmental task force that is now looking at the whole error rate area, and it is being chaired by one of the people from my agency. We anticipate they will complete their work some time in the near future. That relates to how the error rate is designed and looked at.

We had initially begun to look at that in-house and felt that it needed to be broader than just the HCFA study.

Senator SCHMITT. And that looks at the experiences of the various States, both those that are achieving low error rates and those that have been unable to achieve low error rates?

Dr. DAVIS. Yes, sir; it will look at a number of those areas.

When we have States come in with an error rate that is over the target that has been set, that State is required to file a corrective action plan with us, and this is an ongoing effort. Some of the new studies on how to help the States achieve a more significant reduction in the error rate are building on the history of those corrective action plans and the strategies that have been successful.

Through our activities in the Medicare/Medicaid Management Institute we have also offered the States technical assistance as we have identified some areas where there have been problems. That relates again back to their corrective action plans.

Senator SCHMITT. What is the largest source or sources of faulty payment?

Dr. DAVIS. The largest would be the income component.

FAMILY RESPONSIBILITY FOR LONG-TERM CARE

Senator SCHMITT. Errors in eligibility?

Dr. DAVIS. Errors in eligibility. About 70 percent of all of the errors come from errors in eligibility.

Senator SCHMITT. Could you give us a few details on the proposal to require that adult children of medicaid-eligible parents pay a part of the nursing home costs?

Dr. DAVIS. Yes; a number of the States have been interested in what they call family supplementation programs, which are currently prohibited. But we have indicated through a clarification in our regulation that if a State has a law on their books that does not single out medicaid alone in this area, then it would be up to the State as to whether or not they wanted to implement this law in relation to medicaid. We have at least one State that we know of that is in this category and others that are interested in pursuing it. This is not a program that we would force on the States; we would simply give them the option.

Senator SCHMITT. Is there any potential constitutional prohibition on such action, due process or otherwise?

Ms. FEINSTEIN. No, there is not. Except that States will be prohibited from requiring this contribution as a condition of eligibility.

Senator SCHMITT. Excuse me?

Ms. FEINSTEIN. The States will be prohibited from requiring this contribution as a condition of eligibility.

Senator SCHMITT. Do you feel that making such a requirement would have a constitutional implication?

Ms. FEINSTEIN. No, I do not.

Senator SCHMITT. Then why do you prohibit the States from making it a requirement?

Ms. FEINSTEIN. As a condition of eligibility.

Senator SCHMITT. Oh, I'm sorry. I misunderstood you.

I presume adult children means what? Children employed? Or over the age of 18 or 21? Or what?

Dr. DAVIS. It would probably be over the age of 21. We have estimated from a 1976 survey, and again, that's a long time ago, that 17 percent of those individuals who were institutionalized and were on medicaid had at least one child with an income over $15,000. Our current calculations on our savings are based upon an assumption that the States would assume somewhere between a 2- and 4-percent contribution level for those people who were over $17,500 in income. But that's our assumption.

Senator SCHMITT. How would you collect that contribution? Would you assess their tax refunds?

Ms. FEINSTEIN. Let me point out that in order for this to go into effect the States must decide who is a child, the method of collection, and so on. In some States, under current law—and that's why this is only a clarification regulation—they have what is in effect a patient account trust fund as a separate line item in their medicaid budget. Pennsylvania, for instance, does this. If families contribute to the State, it is not directly to the nursing home; it does not offset the payment to that nursing home; it shows up as revenue to the State in a separate line item.

Senator SCHMITT. In a trust fund which then is used to offset medicaid costs overall?

Ms. FEINSTEIN. Yes.

Senator SCHMITT. So the State would not be trying to match a particular adult child's contribution to the parent, but having identified that adult child, would try to get the contribution paid into that trust fund?

Ms. FEINSTEIN. That is the way it is done in Pennsylvania today. How it might be done in other States is very much up to the State. First they must pass, as Dr. Davis indicated, this law of general applicability which states that children are responsible for their parents, whether it be medicaid or other programs. That would be again up to the States.

FEDERALIZATION AND FAMILY RESPONSIBILITY PROPOSAL

Senator SCHMITT. What if we federalized it? How would you handle it?

Dr. DAVIS. Long-term care is one of the areas that we have under discussion now with the new federalism initiative. We would have to look at what the variety of States are doing and would make a determination then as to how it would fit into our program.

I think in terms of a Federal component to it, we would have to assess at that point what the correct level would be in terms of both the income of the individuals, and what percent contribution would be involved.

Senator SCHMITT. Well, I think conceptually it is a good idea. How you are going to implement this thing is not quite clear in my mind.

We would like to believe that every child would be more than willing to contribute what they could to the care of their parents. That certainly was the rural tradition in this country, and as we became more and more urbanized and separate, and more and more mobile, the separation of parent and child in fact and in mind has accelerated. So many children probably would be reluctant to bear that cost and would only do so if you had some means of requiring it, of enforcing that requirement.

There have been proposals to try to collect debts owed to the Federal Government through the withholding of proportions of tax refund checks. There are arguments against doing that in that we try to run a voluntary tax system, and the more you try to withhold from refunds the more the citizen is voluntarily going to withhold from their taxes. So I have not exactly favored that technique for the collection of various types of loan debts owed to the Federal Government.

So this committee would be very interested in how you might implement some program that would insure a reasonable level of adult child contribution to the care of their parents. And as you develop any preliminary thoughts, I hope that you will submit them to us.

Dr. DAVIS. We would be happy to.

RESEARCH BUDGET

Senator SCHMITT. Under research demonstration evaluation, if we are required to make further reduction in support in this area, what areas do you consider more important than other areas?

Dr. DAVIS. We have already taken a 23-percent reduction in this particular budget. At this point in time we have a number of initiatives that are congressionally mandated that we feel we must complete, and we have a competition initiative of some $5 million that we believe is important for us to move forward on.

In terms of what areas we would reduce if we did not get the $30 million, perhaps Ms. Feinstein would like to reply.

Ms. FEINSTEIN. As Dr. Davis indicated, 57 percent of our 1983 budget will fund continuation projects; some 23 percent will support congressionally mandated studies.

We have on the docket for 1983 to take a look at prospective reimbursement in the nursing home areas, to look at prudent buyers in laboratory and home health agency services. We also plan to take another look at the physician assignment problem, how many physicians take assignment—sometimes, all the times, and what are the deterrents to assignment. There are lots of theories on that issue.

We have also a swing bed program evaluation scheduled for 1983, and some work in terms of looking at the changes in the medicaid program as a result of the 1981 reconciliation.

Senator SCHMITT. The various studies that we have been talking about today that you say you have underway, are they funded out of this budget?

Ms. FEINSTEIN. Yes, they are.

Senator SCHMITT. Could you provide us with a detailed list of the studies in those various categories that you mentioned that come under this budget, including the ones that we have mandated over here? We sometimes forget what we mandate. Many of those mandates are compromises to avoid seemingly more serious drains on the budget.

Ms. FEINSTEIN. I would be happy to.

[CLERK'S NOTE.—A copy of the list of studies is in the subcommittee's files.]

Dr. DAVIS. I would like to point out that the research request is flat with no growth from last year. So in effect we already are taking another reduction of 8 percent just to stay within the $30 million target. It represents, too, an investment in our future, and just as prevention is an investment in the future in order to reduce the significant cost outlays. The research component is an investment in the future, because it is here that we test out significant options that can help us in terms of reimbursement techniques.

It is also here where we have discovered a number of areas, which we have already pointed out, where we can take further savings in the program. I would hate to see us mortgage that future much more.

PROSPECTIVE REIMBURSEMENT

Senator SCHMITT. Well, I hate to see it, too, but I will tell you, this has probably been one of the most abused portions of the budget over the years that I have been on this committee. I think it has definitely improved, but there has been no question of abuse in this funding. Very weird things were funded, obviously, in the past. It is important that it serve the purposes that you have outlined in support of your total program and not some additional extraneous purposes that may have been served in the past.

There is growing discussion that an effective means of constraining health care costs would be to move to a prospective reimbursement policy for the Federal health care program. Under such a system an institution would receive a fixed fee at a rate set in advance for a certain number and kind of medical service. Institutions can make a profit if they keep costs below the amount of their fees. Does the administration have any plans to move to a prospective reimbursement system?

Dr. DAVIS. Yes, sir; we do. In a few weeks time I will submit to the Secretary our proposal that relates to the prospective payment system. We have had a task force at work on looking at a variety of alternative methodologies by which one could move to a prospective payment system.

Senator SCHMITT. Have you estimated what the savings may be under such a system?

Dr. DAVIS. Not for 1983.

Senator SCHMITT. What about the drawbacks? Any drawbacks that you have seen? I hope you have done a pro-and-con analysis on it.

Dr. DAVIS. Well, there are always pros and cons to each and every methodology. Even though we have worked with the industry in terms of getting input both from the health care insurers and the provider communities on prospective systems. I am certain that whatever methodology we finally do adopt, there will be differences of opinion.

I happen to be a firm believer in prospective payments. Certainly the experience of the last 16 years with the retrospective cost base system has indicated to us there is no incentive for cost-conscious management. I have talked with a number of the administrators in hospitals that are operating under prospective payments systems as part of our research studies, and they clearly indicate that it gives them the incentive to effectively manage since they can keep some of the additional funds.

Those experiments have proven to us that hospitals can keep the costs down significantly without a negative impact.

BUDGET INFLATION ASSUMPTION

Senator SCHMITT. What is your estimate of the fiscal year 1983 inflation rate in HCFA services, administrative services, the kinds of things other than reimbursements? You said 8 percent is what you are suggesting for fiscal 1983 as the inflation rate. What has been the real inflation rate for fiscal 1982 as you have experienced it?

Dr. DAVIS. For fiscal 1982, the real inflation overall?

Senator SCHMITT. In your budget. Not what people are telling you is the national inflation. But how do your cost increases compare with the national inflation rate?

Dr. DAVIS. For the fiscal year 1982 our increase was 18 percent, and we are estimating for fiscal year 1983 a 15-percent overall increase.

Senator SCHMITT. What I am trying to get at is the kind of costs you have, nonreimbursement costs, costs for research and development, and demonstration, and so forth, what are you seeing as your inflation rate? You said a little while ago that you were having to eat an 8-percent inflation for 1983 by level funding. But what is the real inflation rate? Eight percent is what the administration sort of defines. What is your real rate?

Mr. ITTEILAG. Senator, we have used about 6½ percent in the 1983 budget generally for this purpose, but in many areas there are other things going on so that that 6½ percent doesn't show up. For example, we could have an area of personnel cutbacks that would offset any increase for inflation. So I would say that the budget varies in that respect.

Senator SCHMITT. On those services that you contract for, what do you see, then, as the inflation rate in contract services?

Mr. ITTEILAG. OMB has traditionally in this area prescribed—at least the last several years—two kinds of indices: One they call a Federal nonpay purchase index and the other they call a non-Federal purchase index. For fiscal 1983, the Federal index is about 6½ percent.

Senator SCHMITT. On a Governmentwide basis?

Mr. ITTEILAG. Yes, sir. That index would apply mostly in administrative cost areas and obviously not in the case of procurement of medical services.

Senator SCHMITT. What do you see as the inflation rate in the procurement of medical services? Current rate.

Dr. DAVIS. Again, I would indicate that it is a higher rate than the CPI. We have calculated the medicare benefit component to increase by 15 percent in 1983.

Senator SCHMITT. Medicare?

Dr. DAVIS. Medicare.

Senator SCHMITT. Is medicaid comparable?

Dr. DAVIS. It's 10.

EFFECT OF LOWERED INFLATION ON BUDGET

Senator SCHMITT. Now we have had an inflation rate for the last 6 months that has been closer to 6 percent, I think, than the 9 percent from last year. Have you seen any effect of that in your reimbursement costs yet? Have hospital costs, medical costs in general begun to reflect that declining CPI inflation rate?

Dr. DAVIS. Not as of yet. In the medicare program, no.

Senator SCHMITT. There has been no leveling at all or reduction in the rate of growth of those costs?

Dr. DAVIS. Not at this time.

Senator SCHMITT. Have labor costs continued to accelerate? Have they been increasing faster in the last 6 months than in other professions?

Dr. DAVIS. I don't believe we have the data to break it out separately from our cost reports yet. We would have to submit that for the record.

Senator SCHMITT. Do you know of any labor contract agreements in the hospital industry that have shown a higher than average escalation of wages?

Dr. DAVIS. I don't know of any. We would have to look and submit something for the record.

Senator SCHMITT. If you see anything, we would appreciate knowing in some detail what you see as the real increase in costs in programs that are affected by your activities.

[The information follows:]

IMPACT OF INFLATION

Since there is a delay of several months in the receipt of data, it is too early to tell if declining general inflation during recent months has been reflected in the health care field. Data which are current through late 1981 indicates no reduction in the rate of inflation for health care costs. Furthermore, the most recent CPI data from the Bureau of Labor Statistics indicate that hospital, physician, and medical care prices are continuing to increase faster than the CPI.

Senator SCHMITT. Also, hospital supplies and laboratory costs, are they still going up at roughly the same rate as they were a year ago?

Dr. DAVIS. The ancillary services component of the hospital costs has been rising more rapidly than the inflation has. We don't have any data that would indicate that that has changed.

Senator SCHMITT. OK.

There could be a tendency even in these reduced inflation times for suppliers of essential services to maintain as high a rate of cost growth as they can. I hope that is not true, but it is possible, and I think it would be important for you as well as the Congress to know that it seems to be persisting. But I notice, at least in my travels around New

Mexico, in conversations with consumers as well as business people of basic services, goods and services, such as groceries, there is an obvious leveling of the cost growth of those prices. It is simply stated by one grocer who says "I don't have to change the prices as often as I used to." So we are starting to see some real effect out there of this lower inflation rate of the last few months. The question is, Are we starting to see that in health care costs, too?

Dr. DAVIS. I would anticipate that there is a lag time before one sees that in the health care sector.

Senator SCHMITT. Well, I hope it is not too much of one.

Dr. DAVIS. I do, too.

PREPARED STATEMENT AND SUBMITTED QUESTIONS

Senator SCHMITT. Well we will have some additional questions for the record, and if you will provide your answers at the same time you send back your edited transcript, the subcommittee would be most appreciative.

[The statement and the following questions which were not asked at the hearing but were submitted for response for the record follow:]

STATEMENT OF CAROLYNE K. DAVIS

I am pleased to appear before you today to present the FY 1983 budget request for the Health Care Financing Administration.

One year ago, the reality of inflation and the harm it was inflicting prompted the American people to demand that the Federal government adopt spending reforms. It is even more imperative today that we utilize discipline in Federal spending to further the goals of the President's economic recovery program.

The success of President Reagan's economic recovery program is crucial in our fight against escalating health care costs. For example, our actuaries tell me that each percentage point decrease in the rate of general inflation lowers the cost of the Medicare program by a half billion dollars.

With the enactment of the Omnibus Reconciliation Act of 1981, we began together to control the inflationary costs of the Federally financed portion of our health care system. Medicaid outlays were reduced by $342 million in FY 1982 and by $728 million in FY 1983. Medicare outlays were reduced by $1 billion and $817 million in FY 1982 and FY 1983, respectively.

In spite of these gains, we must take further steps to control the growth of both the Medicare and Medicaid programs. Even with the many reforms we propose for the Medicare program, total FY 1983 expenditures will still increase by almost $6 billion. In addition to the proposals in our FY 1983 budget, the Administration will also submit later this year to the Congress legislative proposals which will be aimed at encouraging greater competition in the health care sector through the promotion of consumer choice.

As you know, the Administration is currently conducting full discussions with the Congress and the Governors on the details of the President's "New Federalism". The President has stated his willingness to be flexible on its specific elements. There is no doubt, however, that he is strongly committed to the the basic concept embodied in this proposal; that is, to return appropriate programs to the level of government closest to the people, so that the dollars spent can be spent more effectively. The Administration is not planning for implementation of the "New Federalism" until FY 1984. In the meantime, we are facing a very difficult budget situation which requires immediate attention.

As a result, our FY 1983 budget contains a series of proposals which reform Medicare reimbursement to hospitals and physicians. We also propose to streamline program administration by eliminating the unnecessary regulatory burden caused by utilization review and PSRO review. Our Medicaid proposals include administrative and program reforms designed to improve efficiency and economy in the program, while ensuring that the truly needy are protected.

I would like now to discuss with you specifics of our appropriations request. The total budget for the Health Care Financing Administration in FY 1983 will be $72.4 billion in outlays: an increase of $5 billion over FY 1982, or 7.4%. When we took office one year ago the rate of increase was almost twice as fast. I am extremely proud of this significant progress in slowing the growth of HCFA's budget.

Our Appropriation request of $32.7 billion, with $856 million to be transferred from the Medicare Trust Funds, will finance the following activity levels in FY 1983:

o	$17.0 billion	-	for Grants to States for Medicaid
o	$15.6 billion	-	Payments to the Health Care Trust Fund
o	$ 25 million	-	for the PSRO Program
o	$ 30 million	-	for Research and Demonstrations
o	$ 704 million	-	for Medicare Contractors
o	$ 51 million	-	for State Certification
o	$ 5 million	-	for End Stage Renal Disease Networks
o	$ 182 million	-	for Administrative Costs

Grants to States for Medicaid

The request for Medicaid is $17.0 billion. This sum is a decrease of $78 million below the FY 1982 levels when both years are placed on a comparable basis. Both the FY 1982 and 1983 budget requests assume the passage of the Administration's legislative proposals.

Major legislation proposed to more effectively control Medicaid include:

-- Transfer of funds for Medicaid Administrative costs to a Consolidated Welfare Administrative Fund (Savings of $1 billion).

-- Reduce the match rate 3 percentage points for all optional services and for all services to the medically needy (Savings of $600 million)

-- Require copayments for certain Medicaid services (Savings of $329 million)

-- Eliminate Federal matching for Medicare buy-in (Savings of $203 million).

As you know, the FY 1982 level for Medicaid was significantly below the President's September Amendments. Based on our current estimates, we still anticipate a shortfall under the Continuing Resolution level. As a result, we are requesting a supplemental appropriation of $553 million to meet our FY 1982 funding requirements.

Payments to Health Care Trust Funds

Our FY 1983 request for this category is $15.6 billion, an increase of $1.2 billion over the level authorized under the FY 1982 continuing resolution. The level requested is broken-down as follows:

-- Federal payment for Supplementary Medical Insurance - $14.5 billion.
-- Hospital Insurance for the Uninsured - $889 million.
-- Military Service Credit - $207 million.

Program Management

The request for program management is $945 million -- $89 million in budget authority and $856 million to be transferred from the trust funds for the following activities:

Professional Standards Review Organizations

The request for PSRO's reflects our continued commitment to phase out the program. We believe that the PSRO's are a costly, burdensome and ineffective means to reduce unnecessary utilization. In lieu of PSRO's, we intend to give Medicare contractors greater responsibility for the identification and reduction of waste in the provision and use of health care services. The strategy to accomplish this is currently being developed and will be designed to parallel and supplement a similar effort in the private sector.

Our proposed funding level, under current law, for the PSRO program is $25 million, including $20 million for hospital reviews, and $5 million for PSRO operating costs. We propose to fund only half of the 130 PSRO's mandated for funding in FY 1982 by the 1981 Omnibus Budget Reconciliation Act. We also propose to reduce the degree of Federal support based on the expectation that those PSRO's with demonstrated effectiveness will be able to continue operations by marketing their services in both the public and private sectors. We are submitting legislation that will eliminate the program effective July 1, 1982.

Research

We are requesting $30 million for research in FY 1983, substantially the same as FY 1982. Resources have been reallocated in order to meet Congressional mandates and to continue only those projects that promote cost savings or management improvement. Lower priority projects will operate with reduced funding or be terminated. We will devote $5 million of the total research budget to studies which will focus on increasing competition in the health care delivery system.

Medicare Contractors

The request for Medicare Contractors is $704 million, the same level provided under the FY 1982 Continuing Resolution. We are committed to reforming and streamlining contractor operations in order to achieve both short and long term efficiencies. These efficiencies will be necessary to allow us to operate with no budget increase from the FY 1982 level, while developing a plan to have contractors increase their utilization review activities.

State Certification

We are requesting $51 million for FY 1983 in State Certification, $19 milllion for Medicare and $32 million for Medicaid: a net program decrease of $2 million, or 4%, below FY 1982.

The total includes an increase of $2.9 million for initial surveys of 1200 new Medicare facilities and $4 million for State cost-of-living increases, which are offset by a reduction of $8.8 million resulting from less frequent surveys of good performers and continuing management improvements. (P.L. 97-35 gave us the authority to survey skilled nursing facilities on less than an annual basis.) This is fully consistent with our goal to reduce unnecessary administrative burden on satisfactory providers while focusing survey efforts on facilities with unacceptable or chronic deficiencies.

ESRD Networks

We are proposing to eliminate the End-Stage Renal Disease Networks effective July of this year. Pending elimination of this activity, funding of $5 million is requested through the program management account. This activity was funded directly in FY 1982 through the trust funds.

Administrative Costs

Our administrative costs request of $182 million, is nearly one million dollars, or 1 percent, below the revised estimate for FY 1982, and assumes a reduction of 730 authorized permanent positions.

I want to make it clear that this request was developed before the President's decision to propose federalizing Medicaid. We are currently examining how enactment of such a policy change would affect staffing needs, and will return to this Committee if our request requires revisions.

The FY 1983 administrative cost level assumes passage of a $5.9 million supplemental appropriation for termination costs associated with the Reductions in Force (RIF) planned to take place in Fiscal Years 1982 and 1983. The FY 1982 RIF of 260 employees and the additional plan to not replace approximately 180 employees lost through attrition are necessitated by the funding level provided under the FY 1982 Continuing Resolution. The FY 1983 budget request assumes the reduction of approximately 500 additional employees and $15 million in personnel-related cost savings associated with both RIFs.

That completes my prepared remarks, Mr. Chairman. I'd be happy to answer any questions the Committee might have.

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

MEDICAID ESTIMATE

Question: This subcommittee has for a number of years been concerned about the accuracy of the Health Care Financing Administration (HCFA) estimates of Medicaid costs. Within the last few years, HCFA changed its method for computing Medicaid estimates. Instead of relying on a computer model, HCFA decided to use the aggregate of all estimates by States as its budget request to Congress. Are you satisfied that this method is acurate?

Answer: Yes. We believe the States' estimates reflect a realistic approach to projecting the Medicaid program's estimated requirements, which are based upon each individual State's Medicaid plan.

Because each State has considerable latitude in determining recipient eligibility, coverage, and methods of reimbursement, considerable variations can exist among each State's requirements. The use of State estimates accomodates the variations which exist between State plans and, therefore, enhances the development of a more realistic national estimate of Medicaid funding requirements.

Question: What changes in your estimating methodologies has the passage of Reconciliation necessitated?

Answer: We have revised our reporting mechanism to accomodate the Omnibus Budget Reconciliation Act modifications which impact upon funding requirements. This has required the development of more detailed information and closer monitoring of State estimates at the regional and central office levels.

The impact of section 2161 of that act is being controlled and monitored at the central office level through the State grants process; and its effect on the overall budget estimates is being monitored on a quarterly basis.

Other provisions generate additional narrative explanations as the States implement individual provisions involving coverage, eligibility, and reimbursement methodology. Many of the Act's waiver and flexibility provisions will not have immediate financial impact on State estimates because of the long lead time required for their implementation. Because some of these provisions are optional on the part of the State, certain provisions will have no financial impact if they are not implemented by the State.

Question: What cooperation, if any, is there between the Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA) in developing Medicaid estimates?

Answer: Communication exists between CBO and HCFA on a continuing basis. HCFA primarily responds to requests from CBO for specific information. CBO then develops its own assumptions for budget projections.

HCFA is working with CBO to highlight differences in assumptions by providing greater detail as to the make-up of the Medicaid program estimates.

MEDICAID SUPPLEMENTAL REQUEST

Question: The Administration is requesting a fiscal year 1982 Supplemental for Medicaid of $552,757,000. This request, however, presumes enactment by July 1, 1982, of significant legislative changes in the Medicaid program to reduce program costs. Without these changes, the size of the supplemental would be $830,757,000. What would be the effect of Congressional failure to provide any supplemental?

Answer: The Medicaid program is an entitlement program whereby the Federal the Federal Government matches the States' expenditures to the extent that funds are available. If supplemental funds are not provided, we would be able to "borrow" funds from the FY 1983 appropriation. This authority to borrow from the subsequent year's appropriation is provided in the current appropriation language.

Question: If Congress fails to enact legislative changes in Medicaid by July 1, what would be the effect of providing only $552 million rather than $830 million?

Answer: Again as an entitlement program, Federal Medicaid funds are provided based upon the States' estimated requirements. If the shortage is partially offset by additional Congressional funding, the remaining shortfall could be borrowed from FY 1983.

Question: This budget predicts that $278 million in savings can be achieved in the fourth quarter. Even assuming enactment of the President's package, is this reasonable? How will these savings be achieved? Will States have time to implement the necessary savings requirement?

Answer: These savings figures are projections; based on enactment of specific legialative proposals. The majority of the savings ($215 million) result from changes in the Federal matching process which can be easily accomplished by July 1 if the legislation were enacted. The remaining savings result from changes in the eligibility standards that would be required to be changed if the legislation were enacted.

Question: As you know, the Omnibus Reconciliation Act significantly tightened eligibility requirements for the Aid to Families with Dependent Children (AFDC) program. As the result of these changes, the AFDC rolls shrank, and thus, the number of people categorically eligible for Medicaid decreased also.

How many persons lost their automatic entitlement to Medicaid as a result of the changes made by P.L. 97-35 in the Aid to Families with Dependent Children program?

Answer: The FY 1983 Budget estimates that 1.1 million beneficiaries will no longer be eligible for Medicaid as the result of the AFDC changes due to P. L. 97-35.

Question: How many persons who lost their automatic Medicaid entitlement as a result of P. L. 97-35 changes to the Aid to Families with Dependent Children program can be expected to regain eligibility under State medically needy programs?

Answer: It is estimated that 15 percent or approximately 200 thousand recipients would have lost their eligibility but would qualify again under the spend-down provision of the medically needy programs.

Question: What is the net fiscal impact of Medicaid of recent changes to the Aid to Families with Dependent Children program?

Answer: The net impact of the P. L. 97-35 provision which relates AFDC to Medicaid will be a savings of $225 million to the FY 1983 budget.

Question: Is there any evidence to suggest that some people are dropping out of the workforce in order to maintain their Medicaid benefits? If so, how widespread is this?

Answer: The Health Care Financing Administration has no evidence to support the conclusion that people are dropping out of the workforce simply to maintain their Medicaid benefits. Isolated examples have been reported in the media; however, there is no general data on which to draw broad conclusions.

MEDICAID ELIGIBILITY REQUIREMENTS

Question: States are required to provide Medicaid benefits to those deemed "categorically eligible"; for example, those who are on Supplemental Security Income or who receive Aid for Families with Disable Children (AFDC) benefits.

States have the option of providing Medicaid benefits to those deemed "medically needy"; that is, people who have enough income or resources to be ineligible to receive SSI or AFDC benefits, but who are considered too poor to pay for necesssary medical care. States are not required to have a "medically needy" component in their Medicaid program.

How many States have altered, or intend to alter, their medically needy programs in response to the flexibility provisions enacted in the Reconciliation Act?

Answer: Tennessee has altered its medically needy program in response to the flexibility provisions.

Question: Have any States eliminated their medically needy programs since passage of Reconciliation?

Answer: No States have eliminated their medically needy programs since passage of Reconciliation.

Question: According to your best estimate, how many people have lost eligibility for Medicaid since enactment of the Reconciliation Act?

Answer: The major changes affecting eligibility relate to the AFDC program. The impact of Section 2300 of the FY 1981 Reconciliation Act reduces Medicaid eligibles by 1.1 million individuals for FY 1983. Included in these estimates is the assumption that 15% of individuals would spend-down and thereby re-qualify for Medicaid.

Question: Where are the persons who have lost Medicaid eligibility obtaining their health services?

Answer: The individuals lost their eligibility because they no longer qualified due to the level of their income or resources. These individuals will be able to meet their routine medical expenses from their own resources, or through a private health insurance offered by their employers. In the States with medically needy programs, those individuals with catastrophic illness will spend-down their resources and thus will regain their Medicaid eligibility.

EFFECT OF RECONCILIATION ON MEDICAID PAYMENTS

Question: The Omnibus Budget Reconciliation Act of 1981 (OBRA) authorized a number of changes in Federal Medicaid payments to States. As a result of reconciliation, the amount of Federal reimbursement to which a State is entitled is to be reduced 3 percent in fiscal year (FY) 1982, 4 percent in FY 1983, and 4.5 percent in 1984. What are the current estimates of Federal savings attributable to this reduction in FY 1982? In FY 1983? In FY 1984?

Answer: In FY 1982, the total savings from the OBRA is estimated at $342 million. The net Federal savings attributable only to the 3 percent OBRA reduction is approximately $394 million. This amount can be summarized as follows:

Total 3 percent reduction		$ 560.3	million
Less:	Offsets for unemployment	-8.1	million
	Hospital rate setting	-53.2	million
	Fraud and abuse	-105.1	million
Net Reduction		$ 393.9	million

In FY 1983, the total savings from the OBRA is estimated at $728 million. The net Federal savings attributable only to the 4 percent OBRA reduction is approximately $572 million. This amount can be summarized as follows:

Total 4 percent reduction		$816.0	million
Less:	Offsets for unemployment	-8.5	million
	Hospital rate setting	-58.7	million
	Fraud and abuse	-112.4	million
	Incentive payments	-64.6	million
Net Reduction		$571.8	million

For FY 1984, the total savings from the OBRA is estimated at $822 million. The preliminary net Federal savings attributable only to the 4.5 percent OBRA reduction is approximately $684.3 million. This amount can be summarized as follows:

Total 4.5 percent reduction		$1,019.3	million
Less:	Offsets for unemployment	-9.0	million
	Hospital rate setting	-65.0	million
	Fraud and abuse	-111.8	million
	Incentive payments	-185.2	million
Net Reduction		$ 684.3	million

Question: How many States have cutback on their own Medicaid programs since the passage of Reconciliation?

Answer: Nine States have cut back on their Medicaid programs since passage of Reconciliation.

MEDICAID STATE AND LOCAL ADMINISTRATION

The Administration is proposing a new Combined Welfare Administration Block Grant to provide states with funds to pay for the administration of the Medicaid, AFDC, and Food Stamp program. This program would be capped in fiscal 1983 at 95% of the fiscal 1982 level, which will produce savings of $259 million.

Question: At a time when the Administration is proposing to insist on a 0% error rate in these programs by fiscal 1986, how do you rationalize capping administrative payments for AFDC and Medicaid?

Answer: Continuing to separate the administrative costs of AFDC and Medicaid will perpetuate inefficiencies in the management of these programs. It will also continue the confusing array of Federal matching for various State-incurred costs. Combining AFDC and Medicaid administrative costs should enable each State to realize savings due to increased efficiencies. States will be able to use such savings to make improvements in their Medicaid programs in a variety of ways, including reducing their error rates. It should be noted that, even aside from Federal incentives to States to reduce their error rates, States accrue savings from reduced rates.

Question: What savings do you believe will accrue as a result of consolidating payments for State administration of welfare programs?

Answer: At the State level, savings will vary based on the manner in which different States take advantage of the potential for improving efficiency. At the Federal level, the administrative block grant would save $302 million in FY 1983.

Question: Since eligibility for these three programs varies, how can a consolidated administrative grant improve management for these programs?

Answer: Receipt of AFDC cash assistance qualifies a recipient for Medicaid. As such, AFDC and Medicaid eligibility are closely linked. Also, in those States with a medically needy program, the process for determining Medicaid eligibility is consistent with that of determining AFDC eligibility for many recipients. Moreover, eligibility is not the only factor these programs have in common; the programs also share a consistent overall goal of improving the lives of their recipients.

Question: How has the reduction in Medicaid payments to States affected their ability to provide services under the Early and Periodic Screening, Diagnosis and Treatment Program?

Answer: The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program remains a mandatory service under the Medicaid program. The 1981 Reconciliation Act mandated a reduction of three percent and four percent in FY 1982 and FY 1983, respectively, to provide an incentive to the States to economize to the greatest degree possible. However, these reductions are not directed at specific portions of the program; reductions to be taken are at the discretion of the State. Therefore, it is unclear at this time if there have been reductions to the EPSDT program.

EPSDT

Question: Are States still required to provide the full range of early and periodic screening, diagnosis and treatment services to medically needy persons if they choose to serve that population?

Answer: EPSDT remains as a mandatory service for the categorically needy population under Medicaid.

Before enactment of the 1981 Omnibus Budget Reconciliation Act (P.L. 97-35), States covering the medically needy could choose to provide one of two sets of services: the same mandatory services (including EPSDT) offered to the categorically needy, or any seven of all the services authorized under Title XIX. Under the 1981 Act, States have much greater flexibility in the array of services they provide to the medically needy. However, this law requires that if a State offers any services to the medically needy, it must provide ambulatory services to medically needy children under 18.

Question: What office now oversees the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and other child health efforts in the Health Care Financing Administration?

Answer: Responsibility for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and other child health efforts is shared by the Associate Administrators for Policy and Operations. The former is responsible for policy and regulatory aspects of such programs; the Associate Administrator for Operations is responsible for day-to-day programmatic oversight.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM

Question: What efforts are Federal, State, and local governments making to coordinate the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program with other programs such as the Maternal and Child Health Block Grant?

Answer: At the Federal level, the Health Care Financing Administration (HCFA) emphasizes EPSDT services collaboration and coordination with related programs of other Federal agencies. A primary objective is to contain costs by reducing duplication and overlaps and to maximize the effectiveness of limited resources. Coordination activities relate the leverage of Medicaid financing with resources development and services delivery programs of the other agencies.

Regulations specifically require cooperation between the Medicaid program and Maternal and Child Health program. In fiscal year (FY) 1981 Public Health Service (PHS) and HCFA realized a goal for PHS supported primary care projects to become EPSDT providers (80 percent) and to provide continuing care (75 percent). These projects in 1981 served 754,800 Medicaid eligible children or 36 percent of their child patients. In FY 1982 PHS and HCFA have a joint workplan to identify barriers and facilitators for coordination with Maternal and Child Health Block Grant enterprises, and EPSDT's integration with primary care projects, in order to advance continuing care arrangements, reduce service overlaps, and contain costs.

Activities with other Federal programs seek to coordinate referrals, develop provider status, assure effective interagency planning, and provide efficient service delivery. Several examples can be given. Head Start refers all Medicaid-eligible enrollees and siblings to EPSDT providers for their required health assessments and necessary follow through. Joint HCFA-Education-PHS initiative uses school districts to promote and extend EPSDT. Housing and Urban Development-EPSDT initiative served to improve delivery of services to eligible children in public housing settings. The Office of Adolescent Pregnancy Prevention has set up three interagency groups with HCFA participation to promote coordination and collaboration.

Increasingly, States and local communities are developing interagency cooperative agreements and closer working relationships based on the Federal level models. These arrangements serve to reduce duplication, contain costs, and make maximum use of limited human and dollar resources.

MEDICAID CO-PAYMENTS

In a number of states, AFDC benefits are regarded as quite low. For example, for an AFDC mother with two children, who relies on Medicaid for health care, AFDC benefits in Alabama are $118 per month. They are the same in Texas.

Question: How do you respond to the criticism that in such States, even modest co-payment charges will represent a severe burden on beneficiaries?

Answer: The cost-sharing levels we have proposed are deliberately low, to ensure that no beneficiaries are unduly burdened. We expect that these levels will discourage inappropriate utilization but not prevent people from seeking necessary care. Under our proposal, the average categorically needy recipient would pay less than $6 per year for physician and outpatient services. The average hospital stay for a categorically needy recipient would require a payment of only $7. We do not feel such cost-sharing levels are too high, even in those States with relatively low AFDC benefits.

MEDICARE CONTRACTORS

Questions: Last year, the Administration's September budget for Medicare contractors was $624 million, some $87 million below the current level, and there was discussion of reducing the budget to this level. How would the Health Care Financing Administration (HCFA) have implemented this reduction, had it been put in place?

Answer: The HCFA budget, authorized at the $691 million level will be achieved through innovative claims/bill processing procedures, cost savings initiatives, and through a system of targeting audits to those providers most likely to yield the best return for audit dollars expended. If the $624 million level were to be implemented, we would abate the entire audit and reimbursement function and cancel the unabated portion of medical and utilization review. The remaining portion of medical necessity reviews required by the Professional Standards Review Organizations (PSRO) should be phased out and other functions primarily affecting beneficiary services would also be stopped.

Question: What effect would a cut of this magnitude have?

Answer: The reduction would have effectively eliminated practically all program dollar safeguards which have been in place since the outset of the Medicare program. The contractors, operating at such a drastically reduced amount, would be able only to process and pay claims without the benefit of any review or audit functions.

PROGRAM MANAGEMENT

PROPOSED SUPPLEMENTAL

Question: Last December, the Administration was asking Congress to approve HCFA's September budget request level, which would have made a severe cut. Now you are asking for a supplemental? How do you explain this seeming inconsistency?

Answer: The September budget request level reflects the President's decision to cut all Federal costs and HCFA's program management budget request was decreased in line with this decision. The program management supplemental that HCFA is now requesting is specifically associated with the costs for a planned reduction in force. These costs are one-time costs that can be isolated separately. Therefore, the reduction in force costs have been placed in a separate supplemental.

HEALTH SYSTEMS ORGANIZATION

Question: Within the Research and Demonstration budget, the amount to be spent on "Health Systems Organizations" is scheduled to increase from $8 million to $11.2 million. Why do you propose this sharp increase in this area?

Answer: The FY 1983 research budget proposes a $5 million new initiative for competition activities. Of this amount $3 million will be allocated to Medicare and Medicaid competition, research and demonstration projects which are included in the "Health Systems

Organization" budget category. Also in the Health Systems category for FY 1983 are funds to conduct Congressionally mandated demonstrations that will test the effects of expanding Medicare coverage to include clinical social workers.

Question: What results do you hope studies in this area will achieve?

Answer: Findings and recommendations in the area of clinical social workers coverage will be included in a Congressionally required report. These competition demonstrations will result in information necessary for the design and implementation of competitive health care delivery systems. For example, we expect to identify incentives that encourage enrollment; effective marketing techniques; administrative and benefit savings; reimbursement methodology refinements; inappropriate incentives (e.g., health plan selection bias or underutilization).

PROGRAM MANAGEMENT-PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Question: Are you intending to terminate additional Professional Standards Review Organizations (PSROs) during FY 1983?

Answer: Yes. Our current law proposed for FY 1983 would provide financial support for only 62 Professional Standards Review Organizations (PSROs). Our present plans are to have no less than 130 PSROs at the end of FY 1982, so we would terminate approximately 68 PSROs in FY 1983.

Question: What criteria will be used to determine which PSROs are to be terminated?

Answer: We have developed extensive criteria for conducting individual Professional Standards Review Organizations (PSRO) evaluations. The major categories are organization and program management, performance of review operations-compliance and process, and performance of review impact/potential impact. All PSROs will be evaluated and scored against common criteria and a predetermined scoring methodology.

PROGRAM MANAGEMENT-STATE CERTIFICATION

Question: What is the status of the Department's efforts to revise State Certification requirements?

Answer: A proposed regulation to refine and streamline the survey and certification process is presently in clearance.

Question: What criteria will be employed to determine which facilities need less than annual certification surveys?

Answer: Criteria are being developed for flexible survey cycles, based upon past compliance testing of each facility.

Question: What assurances do you have that institutions not subject to annual certification surveys will continue to meet the requisite standards?

Answer: We believe that institutions that have continually demonstrated compliance with our annual survey requirements will maintain their performance on a less than annual basis.

Question: In addition to modifying the timing requirement, what other changes, if any, are contemplated in the certification process?

Answer: This regulation is currently under review in the Department. No final decisions have been made at this time.

Question: What savings can be expected from modification in the survey requirements?

Answer: This regulation is currently under review in the Department. No final decisions have been made at this time.

MEDICARE CONTRACTORS

Question: The Committee is concerned that the Health Care Financing Administration (HCFA) may impose requirements and standards on Medicare contractors which do not result in improved performance. What steps is HCFA taking to review, and hopefully reduce, restrictive and unnecessary requirements on Medicare contractors?

Answer: HCFA has had in place for some time a Contractor Performance Evaluation (CPEP) that consists of performance standards all Medicare contractors are expected to meet. The standards reflect what is required by existing policies and operating instructions to contractors - the standards themselves do not impose additional requirements on contractors.

In the extremely tight budget situation HCFA faces in fiscal years (FYs) 1982 and 1983, we have had to look very critically at the requirements we place on contractors. HCFA has underway a major Medicare Administrative Reform Initiative (MARI) designed to both streamline the existing procedures required of Medicare contractors in the administration of the program and to restructure present functional requirements to effect the increased efficiency of operations. Costs saved as a result of streamlining will be used to absorb increased workloads and inflation. The longer range restructuring aspects of this initiative are expected to allow the reallocation of funds to activities which have a high return ratio of program savings to invested administrative dollars.

The overall objectives of MARI are fourfold. First, we seek to reduce and/or reallocate administrative costs to activities which will increase administrative efficiency and cost-effectiveness of operations. Second, we strive to safeguard and increase control over the integrity of program payments. Third, we seek to reduce administrative burden upon the private sector. Last, we strive to assure the minimum levels of service to beneficiaries and providers are maintained.

Several modifications to CPEP have been made in FY 1982 to reflect the cost and burden reduction measures we have taken to live within the severely reduced monies available for contractors' operations. We are revising CPEP standards for FY 1983, using the following guidelines. The standards, criteria and elements should be reduced to those which are truly essential for measuring the "bottom line" product we expect from our contractors--i.e., accurate program payments on a reasonably timely basis at the least administrative costs, with a basic minimum of beneficiary services preserved. Standards should be outcome oriented to the extent possible (i.e., measure result rather than adherence to a process, except in those cases where standardized process is essential (such as the query/reply process and end of line process). The criteria and elements, as well as scoring methodology, should create incentives to assure accurate and cost effective operations.

ALCOHOLISM TREATMENT

Question: There are reports that Medicare and Medicaid are paying considerable amounts of in-patient hospital treatment for detoxification, and other alcoholism-related services. These services are supposed to be paid for on an out-patient basis unless some pressing medical problem requires hospitalization.

* How much do Medicare and Medicaid spend on alcoholism services?

* How many beneficiaries are treated on an in-patient basis?

Answer: At the present time, we are unable to determine how much Medicare and Medicaid spend on alcoholism, nor do we know how many beneficiaries are treated on an inpatient and outpatient basis. This is a result of the manner in which claims are filed for these services. Most physicians do not diagnose alcoholism as the reason for treatment. Instead, the physician is likely to be more specific in his diagnosis, such as by diagnosing "cirrhosis of the liver." Therefore, it is difficult to track expenditures for alcoholism treatment.

* What steps are you taking to make sure that alcoholism services are provided on an outpatient basis?

Answer: HCFA, in cooperation with the National Institute on Alcohol Abuse and Alcoholism, is testing the cost effectiveness of treating Medicare and Medicaid beneficiaries in free-standing alcohol treatment facilities. The free-standing facilities, including half-way houses and outpatient providers, utilize counselors as well as medical staff in the treatment regime. Savings of up to fifty percent are expected with use of the free-standing facilities instead of the currently available inpatient care. The demonstrations are operating in seven states. We expect preliminary results in 1984.

MENTAL HEALTH CARE

Question: A number of studies have indicated that out-patient treatment of mental health patients appears to be at least as effective as inpatient care, though it generally costs much less. What efforts are you taking to try to stress outpatient treatment of mental health patients whenever this is at all possible?

Answer: We are currently conducting demonstration projects with 42 ambulatory mental health providers for outpatient mental health services. The projects began in FY 1981 and we expect results next year.

Question: Will Medicaid and Medicare currently pay for outpatient mental health treatment? What changes in law or regulation would help emphasize this option?

Answer: Within Medicaid there is a broad spectrum of benefits under which outpatient mental health treatment can be covered, including outpatient hospital services; clinic services; physicians' services; drugs; medical or remedial care provided by licensed practitioners (including psychologists); other diagnostic screening, preventive, and rehabilitative services; and home and community-based services. Title XIX grants considerable flexibility to each State in identifying eligible individuals and in establishing its own package of covered services. However, Medicaid regulations preclude a State Medicaid agency from arbitrarily denying or reducing the amount, duration, or scope of a required service (except for home and community-based services covered under a waiver) solely on the basis of diagnosis, type of illness, or condition.

Medicare will currently reimburse for outpatient hospital services, physician services, and nonphysician services (which are provided incident-to a physician's service and under the direct personal supervision of a physician) for treatment of mental illness on an outpatient basis. (With the exception of certain services, such as preventive services, the services provided by Community Mental Health Centers are also covered under Medicare under these categories.) The statute limits reimbursement for mental health treatment for persons who are not inpatients of a hospital to $250 in a calendar year (section 1833(c)). An administrative determination was made early in the Medicare program to apply this limitation only to physician services.

Although there may be a number of legislative or regulatory modifications that would increase current emphasis on outpatient mental health treatment, we do not have adequate information at this time to list specific changes that could be made. We believe various aspects of the current rules would need to be studied to determine what the effect of any changes would be and what types of modifications would be most appropriate in light of all the factors to be considered.

Question: How many beneficiaries under Medicaid receive mental health treatment? How many under Medicare? How many of these receive outpatient treatment?

Answer: In 1980, the Department's Steering Committee on the Chronically Mentally Ill estimated the numbers of Medicare and Medicaid beneficaries receiving covered services. It was estimated that 601,481 Medicaid beneficiaries and 419,000 Medicare beneficiaries, who had been diagnosed as chronically mentally ill, received covered mental health services. Outpatient services were provided for 337,138 of these Medicaid beneficiaries and for 215,000 of these Medicare beneficiaries. There are no estimates of the number of nonchronic patients receiving mental health benefits under either program.

The Health Care Financing Administration, the National Institute for Mental Health, and the Assistant Secretary for Planning and Evaluations are conducting a 3 year demonstration, which began in FY 1980, to assess the impact and benefits of cost-related Medicare reimbursement for non-hospital operated community mental health center, organized ambulatory mental health service settings, and partial hospital-home facilities. The demonstration could result in recommendations to change Medicare coverages and reimbursement practices so as to expand the use of outpatient mental health services.

END STAGE RENAL DISEASE NETWORKS

Question: Why has the decision been made to make the End Stage Renal Disease networks a part of the Program Management Account?

Answer: We decided to show the networks as a discrete activity because we felt it was inappropriate to continue including funding requirements under Medicare benefits and we felt they should be subject to the scrutiny of the appropriations process.

Question: What plans does HCFA have for the ESRD networks?

Answer: We are proposing legislation to eliminate the End State Renal Disease (ESRD) networks as they are largely ineffectual. The networks have poor performance records and are not consistent with the competitive health care system. The networks represent an intrusive regulatory mechanism.

NON-INSTITUTIONAL TREATMENT

Question: It has been suggested that one way to reduce the cost of the Medicaid and Medicare programs would be to stress more aggressively certain non-institutional forms of treatment--for example home health care instead of hospital-based or nursing-home based treatment. What evidence is there to document that non-institutional care can reduce health care costs?

Answer: A number of states have conducted demonstration projects that are experimenting with community based care alternatives to institutionalized long term care. Although some of the evidence has been mixed, most of these early projects have reported savings of up to 50 percent of the average cost of institutionalized care. We are currently conducting a cross-cutting evaluation that will provide additional information on the cost effectiveness of community based care. Results are expected in 1983.

Question: What steps is the Health Care Financing Administration (HCFA) taking to try to stress the option of non-institutional care for Medicaid and Medicare beneficiaries?

Answer: HCFA has a long-term care policy group which examines the interrelationships of all the activities in the agency pertaining to long-term care and develops recommendations for improvements. Home health care is a major area of consideration on this year's agenda.

For several years, HCFA has conducted demonstrations of community based services as alternatives to institutionalized care. These projects have included assessments of the needs of patients and the most appropriate settings for delivering services to them. Two examples are the Monroe County, New York, ACCESS project and the Georgia Alternatives project.

HCFA is also promoting non-institutional care through implementation of the waiver authority under Section 2176 of the Omnibus Budget Reconciliation Act of 1981, which allows States to expand community-based care benefits under Medicaid.

Question: What changes in the Medicaid or Medicare statutes could help change the bias in these programs to stress non-institutional kinds of care?

Answer: Although there may be a number of legislative modifications that would increase current emphasis on non-institutional types of care, we do not have adequate information at this time to list specific changes that could be made.

MEDICARE AND MEDICAID FRAUD

Question: Last year the FBI testified in House hearings that those committing Medicaid fraud had little or no fear of being caught. Do you believe that this is still true?

Answer: I believe that in a program that spends as much money and affects as many people (both beneficiaries and providers) as the Medicaid program, there will always be those few individuals who attempt to take advantage of the system through fraudulent behavior. However, the investigations and prosecutions of the State Medicaid fraud control units prove that many individuals are, in fact, being caught and penalized accordingly. Congress' action in the 1980 Omnibus Reconciliation Act to continue to fund fraud control units after their initial 3-year operation, ensures that these units will continue to investigate and prosecute those who commit fraud as well as providing an incentive for States to create units which had not yet formed separate units by 1980.

Section 2161 of the 1981 Reconciliation Act provides an added incentive for State fraud control units and Medicaid State agencies to operate effective fraud and abuse detection and investigation programs and to strengthen these programs.

The Civil Money Penalty program provides an important deterrent and a strong tool to ensure that those who commit fraud will be penalized.

I do not believe those committing Medicaid fraud have little or no fear of being caught and in fact recent legislation and actions by the Federal and State governments have increased the probability of fraud detection, investigation, and imposition of penalty.

Question: In fiscal 1981, how many cases of Medicaid and Medicare fraud were brought to trial?

Answer: For FY 1981, the Office of the Inspector General referred 303 cases for prosecution. They do not maintain records as to how many cases relate specifically to Medicaid and Medicare. However, for calendar year 1981, 91 cases were referred to U.S. attorneys related to Medicaid and Medicare. The State Medicaid Fraud Control Units reported 317 indictments and 275 convictions for FY 1981, allrelated to Medicaid.

Question: Are you satisfied with this performance?

Answer: I am not satisfied with this performance and as a result we have intensified the emphasis in HCFA to ferret out waste and abuse and in addition, we are working directly with the Office of the Inspector General to make certain that we obtain the most effective utilization of resources and that we leave no stone unturned to get at the root of the problem. We are also putting forth a concerted effort to identify and close loopholes in our policies and procedures that might otherwise create a favorable climate for the perpetration of fraud, waste and abuse.

I am concerned as to the lengthy delays involved in the ultimate disposition of those cases; particularly those that may be declined for prosecution since some administrative action may be appropriate in many of those cases.

Civil Money Penalty Program will help to ensure that some punitive action is taken on those cases that we have referred to the Inspector General but have been declined for prosecution by the U.S. Attorney.

MEDICAID WAIVERS

Question: How many States have applied for a waiver to provide home and community-based services, as provided under the Omnibus Budget Reconciliation Act of 1981?

Answer: To date, 13 States have requested waivers under section 1915(c)of the Act to provide home and community-based servcies to individuals who would otherwise require institutional care. These States are: Oregon, Louisiana, Montana, Florida, California, Georgia, Tennessee, Minnesota, Vermont, Kansas, Missouri, Rhode Island, and Nevada. Florida and California each requested two waivers, and Kansas requested three. Approvals have been granted to Oregon, Louisiana, and Montana.

Question: How can we encourage more States to take advantage of the waiver for community-based care?

Answer: Information gathered informally from our regional offices and contacts by various State representatives indicate continued interest in the section 1915(c) waiver requests. Regional and central offices personnel have conducted training seminars and provided technical assistance for State representatives.

Question: How much will the new community-based care waiver cost the Federal Government and the State? How much might it save?

Answer: Congress estimated that this provision, as it appeared in H.R. 3982, would save $20 million in fiscal year 1982. There is some concern that this benefit may result in an increase of Medicaid costs, due to a number of variables. We estimate that there will be savings for the 13 States that have currently aplied for waivers under the home and community-based provision which are approved. However, at this time, we have neither the program experience nor information needed to make an accurate estimate of the costs or savings.

REDUCING LONG-TERM CARE COSTS

Question: What long range plans does the Administration have to curb long-term care costs?

Answer: The Administration is considering a number of alternative solutions to the problem of the high cost of long-term care. Since most of our present long-term care programs are administered at the State level, we are primarily exploring solutions which will give States the flexibility they need to control costs. Some of these initiatives include:

+ Implementing section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) which permits States to request waivers to include in their Medicaid plans approved home or community-based services to individuals who would otherwise require care in SNFs or ICFs; and

+ Conducting a series of projects to assess the effectiveness of channeling-type programs with regard to controlling long-term care costs.

Question: Is the Department pursuing a block grant approach for funding long-term care under Medicaid?

Answer: Block grants for Medicaid long-term care services are but one of a number of options we are exploring as part of the New Federalism effort. However, at the present time, no final decisions have been made with regard to which option we will be pursuing.

COMPETITION AND LONG-TERM CARE

Question: Is is possible to inject competition into the area of long-term care?

Answer: At the present time the Department is examining various ways of injecting competition into the area of long-term care (LTC). However, since we recognize that there are significant differences between acute care and LTC, we do not propose to include LTC services in our initial competitive proposal until we have analyzed the differences and determined the most appropriate method of utilizing competitive forces to improve financing and delivery of such care. Our decision to separate acute care and LTC competitive strategies was based upon several considerations.

+ Since virtually no private insurance market exists for LTC services, vouchers for LTC insurance would not be feasible at the present time. The extent to which private insurance markets can be created for LTC services is unknown. Moreover, insuring LTC services may have undesirable side effects such as increasing costs if improved access to the formal care system displaces informal care by family and friends.

+ Competitive strategies designed to increase the amount of information available to consumers so that they can better select among alternatives have little relevance in areas where there are few LTC alternatives available. In addition, some of the LTC population is incapacitated to the point where they are unable to manage their own affairs nor do they have family and friends who can make decisions for them.

+ Competition among nursing home providers may be difficult to generate since in many areas there is a shortage of such homes and extensive waiting lists for admission.

While we do not view these problems as unsolvable, we are deferring inclusion of LTC in our initial competitive strategy until we have assessed the effectiveness of various proposals which would address the special problems associated with LTC.

LONG TERM CARE

Question: A number of states use a prospective reimbursement payment system for the long-term care component of their Medicaid programs. What success have these states had in holding down long term care costs?

Answer: We have no evaluation data to compare the experience of prospective reimbursement vs cost-based reimbursement for Medicaid long term care benefits. Most states set Medicaid nursing home rates prospectively. We do know that the average cost of Medicare long term care, which is cost-based, is higher than Medicaid long term care.

Question: How many States are using this system?

Answer: Currently, 40 States reimburse at least one level of care of their long-term care program on a prospective reimbursement system. The remaining States use exclusively Medicare principles or other cost reimbursement systems.

MENTAL HEALTH CARE

Question: During its deliberations on last year's budget the Committee urged HCFA to give priority to supporting projects within its usual procedures that addressed the relationship between mental health care and physical health costs. Studies have indicated impressive potential for cost-savings to both Medicare and Medicaid, if quality mental health care were to be made readily available to those individuals with emotional distress who otherwise will utilize physical health care services. To date the Committee is not aware of any actions taken by HCFA in response to the Committee's interest. Accordingly, the Committee would appreciate learning of HCFA's plans to address this matter.

Answer: In conjunction with the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), HCFA is implementing two major initiatives which will expand mental health coverage to Medicare and Medicaid beneficiaries. The mental health demonstration will test the impact of coverage by Medicare of ambulatory mental health services, such as free standing community mental health center services and partial hospital services. The alcoholism demonstration will determine the cost effectiveness of expanding Medicare and Medicaid coverage to free standing alcoholism treatment centers. The evaluations of both projects will attempt to examine the relationship between mental health care and physical health costs. At this time, HCFA does not plan to initiate any new projects in this area due to limitations of the research budget.

RURAL HEALTH CLINIC ACT

Question: The Committee would appreciate learning whether HCFA has developed any data from its experiences with the provisions of the Rural Health Clinic Act, regarding the cost-effectiveness of nurse mid-wifery services.

Answer: We have no information on the cost effectiveness of midwifery services. Although nurse midwives are covered under the Rural Health Clinic Act, the Medicare cost reports do not distinguish between nurse - midwives and other professionals. Thus, cost comparisons are not possible.

BIRTHING CENTERS

Question: The Committee has become aware of reports that charges at "birthing centers", which are traditionally administered by certified nurse-midwives, have been demonstrated to range from 37.6% to 66.1% of in-hospital care costs. Specifically, the Committee has learned that whereas the Maternity Center Association's Childbearing Center of New York charges Medicaid approximately $1,000 per birth, that in a representative group of hospitals, that State's Medicaid program is paying from $1,854.97 to $2,304.93 for normal maternity care with a total three-day hospital stay, or approximately $855 to $1,300 more per birth. There also does not appear to be any evidence that would suggest that the overall quality of care in "birthing center" is inappropriate. Accordingly, the Committee would like to know why HCFA has not given appropriate priority to funding demonstration projects in this area, and in particular, why HCFA has not yet published the certified nurse-midwife regulations that were mandated in the Budget Reconciliation Act of 1980, P.L. 94-499.

Answer: HCFA has many competing projects for limited demonstration funds. At the current time, we are funding a demonstration that is designed to improve early access to obstetrical care through Medicaid reimbursement incentives and coverage of preventive services such as health education and nutrition. Since the HCFA research budget has been substantially reduced, at this time we are unable to allocate additional resources to further examine the demonstrated cost-effectiveness of birthing centers.

PHYSICIAN EXTENDERS

Question: In reviewing the Department's budget justification for FY '83, it appears that HCFA has no plans for studying the potential cost-effectiveness of directly reimbursing nurse practioners/clinical specialists for their services under Medicare and Medicaid. The Office of Technology Assessment recently released a background paper expressly addressing this issue (Case Study #16) in which considerable evidence was presented that these non-physician practioners can, in fact, provide many of the services traditionally provided by physicians, and in a manner consistent with high quality care. It seems logical that the Administration's "Competition oriented" proposals should take a careful look at inter-professional competition possibilities. Accordingly, the Committee would appreciate learning from HCFA what plans it has for this kind of competitive strategy?

Answer: HCFA is planning to approve demonstration projects to test alternative competitive approaches for Medicare and Medicaid. As part of the evaluation, an assessment will be made of personnel arrangements including levels of staff and reimbursement methods. In addition, as part of the urban clinic demonstration to be funded this year, HCFA will consider the effects of direct billing for physician extender services.

Question: What cost-savings might evolve from more active nursing involvement in our nation's nursing homes, which remain one of the fastest growing expenditures under Medicaid?

Answer: We do not have any data that would allow us to project cost-savings or additional costs that might result from increased nursing involvement in nursing homes.

SUPPLEMENTARY MEDICAL INSURANCE

Question: The fiscal 1982 budget for Supplementary Medical Insurance (SMI) (Medicare Part B), was predicated on a 12% contingency margin. In the fiscal year 1983 budget, HCFA is now informing the committee that in both fiscal year 1982 and 1983, a 7% contingency margin was all that you need or intend to use.

- What is the basis for this change in policy?
- How is an actuarially sound level for SMI determined?

Answer. The 12% level was based on the best judgement at that time, of our Office of the Actuary. During the past year, however, our actuaries completed a study of the financing of the Part B Trust Fund. The result of this study was the determination that while the 12% policy insured that the Part B program satisfied measures of actuarial soundness, it also led to the fund accumulating substantial funds that were not necessary for program payments. It was the judgment of the actuaries that a 7 percent contingency would be adequate to insure actuarial soundness without an excessive balance.

Question: According to your budget justification for Supplementary Medical Insurance (SMI) (page 39), HCFA has underestimated the number of aged beneficiaries in the SMI program, with resultant increases in program costs.

- Are you satisfied with HCFA's methodology for estimating the number of beneficiaries for Medicare Part B benefits?
- What can be done to improve these estimates?

Answer: The estimates of the aged population under the SMI program as cited in the Budget Justification reflect changes of from 1/10 of 1% to 2/10 of 1% over the prior estimates. These changes are extremely small in both absolute and relative terms. Although an increase in the population estimates will generally produce increases in the estimated costs, the differences, due to this change, are extremely small, and it would be virtually impossible to improve upon that degree of accuracy.

FREEDOM OF CHOICE WAIVERS

Question: Last year's reconciliation bill allowed States to apply for so-called "Freedom of Choice" waivers which allow a State to limit the health care providers to which Medicaid beneficiaries may go for services. States believe this will help restrain Medicaid costs. How many States have applied or are expected to apply for such waivers?

Answer: To date, we have received 28 waiver requests from 24 States. We estimate that we will receive a total of 50-60 waiver requests by the end of this fiscal year. We believe that by then remaining States will have submitted at least one request a piece.

Question: What are the general characteristics fo the Freedom-of-Choice Waivers?

Answer: Of the 28 waiver requests received to date, 16 deal with home and community based services authorized by section 1915(c) of the Act. The remaining 12 deal mainly with requests under 1915(b) to establish primary care case management systems. Among the twelve 1915(b) requests, there are several proposals for co-payment. In addition, Wisconsin is considering the feasibility of using restriction of beneficiaries to certain providers who meet specified standard.

RECONCILIATION - MEDICAID EXPECTATIONS

Question: Under Reconciliation, each State will receive a 3 percent across-the-board reduction in Federal Medicaid payments. For each of the following a State can lower the amount of its Medicaid funding reduction 1 percent: operating a qualified hospital cost review program; having an unemployment rate exceeding 150 percent of the national average; and demonstrating recoveries from fraud and abuse reduction activities equal to 1 percent of the Federal payment. A State also qualifies for an offset in its 3 percent reduction under Reconciliation if it can hold the increase in Medicaid costs to less than 9 percent from fiscal year (FY) 1981 to FY 1982. How many States will not be subject to the full reduction on Federal Medicaid payments in FY 1981 because they qualify for one or more of the exceptions?

Answer: The Omnibus Reconciliation Act of 1981, section 2161, provides that the reduction will be for the amount of payments which a State is otherwise entitled to receive for any quarter in FYs 1982, 1983, and 1984. Therefore, in FY 1981, none of the States will be subject to the full reduction in Federal Medicaid payments.

Question: How many States are expected to be granted an exception from the full Medicaid reduction in FY 1982 based on operation of a qualified hospital costs review program? Which ones?

Answer: Seven States qualified for the 1 percent rebate for qualified hospital cost review program. They are: Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, and Washington.

Question: How many States are expected to be granted an exception from the full Medicaid reduction in FY 1982 based on recoveries from fraud and abuse control activities and third-party recoveries? Which Ones?

Answer: HCFA is in the process of determining which States will qualify for the 1 percent rebate for fraud and abuse and third-party recoveries. At this time the data indicates 75 percent and 50 percent of the States will qualify for FYs 1982 and 1983, respectively.

Question: What is the fiscal impact of the exceptions from the full Medicaid reductions in FY 1982?

Answer: The total impact of the exceptions in FY 1982 is $166,404,000 and consists of: $53,283,000 - 1 percent rebate for qualified hospital cost review programs; $8,054,000 - 1 percent rebate for unemployment; and $105,067,000 - 1 percent rebate for fraud and abuse recovery.

Question: Are any States expected to fall below their target amounts in FY 1982 and thereby qualify for an offset in their reductions? Which ones?

Answer: At this time, HCFA has not received the information necessary to determine which States do not exceed their target. However, the available data indicates that the following States will not exceed their target growth rate: Arkansas, Delaware, District of Columbia, Florida, Kansas, Massachusetts, Nebraska, New Hampshire, New Jersey, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Utah, and Virginia.

RESEARCH PROJECTS

Question: It is my understanding that the Health Care Financing Administration has plans underway to terminate funding for $6-7 million of continuing research and demonstration projects in order to make room for $6-7 million of new starts. Is this an accurate statement?

Answer: In FY 1982, we have proposed termination of approximately $6-7 million in planned projects. However, 70 percent of our planned terminations are decisions not to initiate new projects. We plan to terminate only a small number of ongoing projects. These continuation terminations are targeted towards lower priority projects.

Question: If so, what is the reason for this?

Answer: HCFA's research budget was significantly reduced in FY 1982 and 1983. In order to provide funds for Congressionally mandated projects and new administration priorities in the area of competition, it was necessary to reallocate resources.

Question: Which new projects is HCFA planning to undertake?

Answer: We plan to initiate new projects to promote competition in the Medicare and Medicaid programs. We also plan to initiate projects mandated by Congress such as AFDC Home Health Aide demonstrations; Clinical Social Worker demonstrations; Hospital Closure and Conversion evaluation; HMO Termination Study.

Question: Are there any statutory or regulatory guidelines governing the termination of continuing research projects? If so, what are they?

Answer: Federal Grants Administration Manual and the Federal Procurement Regulations provide instructions for termination of continuation projects. Grants may be terminated for cause or due to lack of funds. Contracts may be terminated for cause or for convenience of the government. Contract terminations require negotiation over close-out costs.

MEDICAID LEGISLATIVE PROPOSALS

Dr. Davis, as I am sure you know, this Subcommittee is extremely concerned about the escalating cost of the entitlement programs. The Administration has suggested a number of reforms of the Medicaid program, many of which are considered somewhat controversal.

Question: Could you briefly describe what these reforms are?

Answer: The following are our major proposals for reducing the costs of the Medicaid program.

-- Require States to impose nominal copayments for physician, clinic, and outpatient and inpatient hospital services.

-- Permit States, under certain conditions, to collect contributions from adult children for the cost of care provided elderly parents in institutions.

-- Allow States to impose liens on the property of recipients who reside in long-term care facilities.

-- Reduce Federal matching for erroneous Medicaid payments in excess of 3 percent in 1983.

-- Lower by 3 percentage points the matching rate for optional services to optional coverage groups

-- Provide a combined administration block grant to the States for the administration of the Medicaid, Aid to Families with Dependent Children (AFDC), and Food Stamp programs.

-- Match administrative costs of State certification activities at 50 percent.

-- Eliminate Medicaid matching for States which pay the Part B premium for their dual Medicare-Medicaid beneficiaries.

Question: What other alternatives for reducing Medicaid costs were considered, but not included in the President's budget?

Answer: We carefully considered many options for controlling the costs of Medicaid, before we decided upon the proposals described above.

MEDICAID CO-PAYMENTS

Question: What mechanism will there be for health care providers to collect their co-payment fees from beneficiaries?

Answer: Medicaid will use the same mechanism as Medicare used to collect these fees from the beneficiaries; that is the providers will collect the fee from the beneficiary either at the time of service delivery, or else later through their normal billing process.

Question: In many cases where doctors and hospitals have trouble collecting co-payment fees, won't these costs have to be absorbed and probably never collected?

Answer: The dollar value of these fees is relatively small, so that most beneficiaries will be able to pay the fees at the time of the delivery of the service.

Question: How does charging co-payment fees fit in with the goals of the Early and Periodic, Screening, Diagnosis and Treatment program, which is designed to encourage preventive health care for young children?

Answer: No specific research has been done on the imapct of co-payments on Medicaid services for children.

We believe that co-payment levels in the Administration's proposal have been set at sufficiently low levels so as not to discourage early intervention or needed care. For example, the average Medicaid recipient, with an average of 4.5 physician visits and one clinic or outpatient department visit will be required to contribute less than $6 annually for physician services (medically needy recipients would on average contribute $9 per year). Categorically eligible Medicaid recipients would contribute only $7 toward the cost of care for the average hospital stay. Medically needy recipients would contribute $14.

These data do not distinguish between average numbers of services provided to other EPSDT population as opposed to all other Medicaid recipients. However, since expenditures for children under age 21 account for only one-third of Medicaid physician and outpatient hospital expenditures, it is expected that average annual Medicaid co-payments for children receiving EPSDT services will be less than those for the Medicaid population as a whole.

Question: Can HCFA promise to have a 0% error rate in the Medicare program in fiscal 1986?

Answer: In the Medicaid program, eligibility is based on an individual's income and resources; these, of course, are subject to change and determining eligibility is a complex, ongoing effort. We monitor State activities in this area to encourage a high level of proper eligibility determinations. The Medicare program is entirely different in that eligibility is based on receipt of Social Security benefits and (in almost all cases) attaining age 65. Medicare eligibility determinations are not based on an assessment of need and do not need to be repeatedly re-evaluated. Such determinations are therefore, very straight forward and do not require the type of monitoring required for Medicaid.

SWING-BED REGULATIONS

Question: What advantages and disadvantages do you see to the swing-bed proposal?

Answer: From the Health Care Financing Administration's viewpoint, the major advantage is a cost-effective means of meeting an unmet demand for nursing home beds for Federal program beneficiaries. Allowing small rural hospitals to "swing" their beds encourages them to efficiently use underutilized resources and provides them with flexibility to meet fluctuating demands for hospital and long-term care. One potential disadvantage we foresee is a possible shifting of costs for Medicaid and private-pay long- term care patients to Medicare hospital patients under the swing-bed reimbursement method. This will occur if non-Medicare patients have greater utilization of the long-term care services than Medicare beneficiaries and the payment rates for those services are insufficient to cover the incremental costs of providing them.

Question: Has a decision been reached on whether to impose these additional regulatory burdens on hospitals wishing to participate in the swing bed program?

Answer: A final decision has not yet been reached in the Department on these issues.

Question: By what date will regulations be issued? Please be specific.

Answer: We expect to issue a Notice of Proposed Rulemaking (NPRM) this spring.

Question: What is the rationale for the Administration's desire to eliminate the PSRO program?

Answer: In general, expected cost savings have not been realized and repeal of the program will eliminate Federal costs and burdensome regulatory involvement. Elimination of the Professional Standards Review Organizations program will create a setting more conducive to competition in the private sector.

Question: How effective was the transition back to utilization review in those areas where Professional Standards Review Organizations (PSROs) have been terminated?

Answer: We know of no major problems arising in the transition back to utilization review.

Question: To what extent does the Department of Health and Human Services intend to monitor the effectiveness of utilization review in areas where PSROs have been terminated?

Answer: State Survey Agencies, in the conduct of their surveys to assure that providers meet the Conditions of Participations for Medicare and Medicaid, will review provider utilization review activities for compliance. The Federal Regional Offices will also review hospital utilization review plans.

Question: How many States are expected to contract with PSROs to perform required Medicaid review functions?

Answer: Professional Standards Review Organizations (PSROs) in Iowa, New York, New Jersey, Vermont, Washington, Colorado, Montana and California have already worked out relatively firm agreements. PSROs in Alabama, Mississippi, North Carolina, Florida, Illinois, Ohio, Indiana, New Mexico, Oklahoma, South Dakota, Nevada and Oregon are presently actively involved in negotiating their arrangements. Georgia, Pennsylvania, Michigan, Utah and North Dakota have made definite decisions not to contract with PSROs.

Question: What percentage of Medicaid hospital admissions are expected to be covered by PSRO review?

Answer: For 1983 budget estimating purposes, we assumed approximately 1.8 million Medicaid reviews. However, until such time as contracts between States and PSROs are finalized, we are unable to more accurately estimate the number of Medicaid hospital admissions that will be covered by PSRO review.

Question: What types of alternative Medicaid review mechanisms will be used in areas which do not contract for review by PSROs?

Answer: We expect considerable variation in approaches, but it is still too soon to identify what these approaches will be.

MEDICARE CONTRACTORS

Question: The committee understands that audits performed by Medicare contractors have a very high benefit-to-cost ratio. How much of the fiscal year (FY) 1982 budget for Medicare contractors is to be used for audits? How much of the FY 1983 request?

Answer: At the FY 1982 funding level of $684 million, which excludes $20 milion contingency, we plan to spend $39.1 million for the audit, desk review, settlement and hearing functions. If, as projected, the FY 1983 approved funding level remains at $684 million, we will spend $41.5 million for the same functions.

Question: What does HCFA estimate the benefit-to-cost ratio for Medicare contractor audits of providers to be?

Answer: Based on statistics gathered by the Health Care Financing Administration, we estimate that the benefit-to-cost ratio for Medicare contractor audits of providers will be $5 of benefits for each dollar of audit costs.

MEDICAID QUALITY CONTROL

Question: What is the largest source of faulty payment: errors in eligibility, third party liability for payment, or claims processing errors?

Answer: The largest source of faulty payment is for errors in eligibility determinations with misspent funds amounting to $504.2 million for the April-September 1980 period. Claims processing misspent funds for that period were $56.9 million and for third party liability errors, $39.7 million.

Question: What is the current national payment error rate for Medicaid?

Answer: The national payment error rates for the April-September 1980 period are as follows:

	Error Rates
Eligibility (excluding SSI)	5.0%
Claims Processing	.5
Third Party Liability	.3

Question: What steps can be taken to create the fear among both providers and beneficiaries that Medicaid cheating simply cannot be tolerated?

Answer: I believe the best method to deter fraud and abuse in the Medicaid program is one where those individuals contemplating "cheating" recognize that there is a strong probability that they will be promptly detected, investigated, and punished if they engage in such behavior. Both providers and beneficiaries should be aware of the various penalties and sanctions that can be levied against those that cheat. I believe that investigations and prosecutions by the State fraud control units and the Department's Inspector General's Office, and the administrative sanctions program administered by HCFA, contribute to the perception that those who contemplate fraudulent or abusive behavior will be caught. I strongly believe that the Civil Money Penalty Program, passed by the Congress last year, will provide a very important tool to penalize those who cheat the program and will provide a strong deterrent against fraudulent behavior in the Medicaid program.

MEDICAID LONG-TERM CARE RFORM

Over the past several years, payments for long-term care have made up an increasing part of the Medicaid budget. This year, the Administration is proposing to allow States to require that the adult children of Medicaid-eligible parents pay part of nursing home costs.

Question: What kind of limitation would there be on the amount an adult child would be expected to pay?

Answer: The Federal government would not establish such limitations. Each State would have the authority to determine the amount an adult child would be expected to pay. In making such determinations, we expect States to set reasonable guidelines which take into account the adult child's income and resources, as well as other responsibilities.

Question: How much savings do you expect this proposal to yield in fiscal year 1983?

Answer: We have estimated FY 1983 savings to the Federal government of $104 million from this provision.

RESEARCH, DEMONSTRATION AND EVALUATION

Question: Within the overall total of the HCFA budget, the $30 million provided for Research, Demonstration and Evaluation is a small amount. The Committee is still concerned, however, about the use made of this money. Please describe ways in which studies funded through this program have helped reduce health care costs?

Answer: Research, demonstration and evaluation results have influenced Medicare and Medicaid legislation, regulations and program policy in a number of major areas and have produced program savings that far exceed research costs. Selected examples of research related savings include: reduction of the Medicare nursing differential from 8 1/2 to 5 percent with recommendations for further reductions; elimination of the private room differential under Medicare; reductions in payments to hospitals for medical malpractice insurance; development of a methodology on hospital classification and casemix resulting in section 223 limits on routine hospital costs; reduction of hospital costs 2%-6% through prospective hospital reimbursement demonstrations; refinement of the Medicare Economic Index resulting in 3.5% lower physician payments under Medicare; evidence to support recommended reductions for payments to hospital based physicians; evidence to support coverage of swing bed reimbursement in rural areas; development of prospective Medicare reimbursement to HMO at lower than the average fee-for-service cost; evidence to support changes in reimbursement for durable medical equipment (purchase vs. rental), streamlined methods of nursing home survey and certification review.

Question: Why should the Federal government continue to spend this amount on research in this area?

Answer: Health care has experienced one of the largest cost increases of any sector in the entire economy. Through Medicare and Medicaid, the Federal government contributes approximately 26 percent of total health care costs (40 percent of hospital costs). This Federal share will increase as a result of demographic trends. Further Federal responsibility will be incurred if Medicaid is federalized. Therefore, efforts to reduce the increase in health costs have a direct, financial payoff to the Federal government. Federal investment in health financing research has a proven track-record in developing delivery system alternatives that are cost-effective. In the FY 1983 budget alone, the savings from the elimination of the private room differential alone is almost double the cost of the research budget. In 1982, the reduction of nursing differential resulted in $95 million in savings.

SUBCOMMITTEE RECESS

Senator SCHMITT. We will now recess until Wednesday, March 10, when we will meet in 1224 Dirksen at 10 a.m. to discuss appropriations for the Social Security Administration, including the Office of Refugee Resettlement.

[Whereupon, at 11:15 a.m., Monday, March 8, the subcommittee was recessed, to reconvene at 10 a.m., Wednesday, March 10.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

WEDNESDAY, MARCH 10, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:05 a.m., in room 1224, Everett McKinley Dirksen Senate Office Building, Hon. Lawton Chiles presiding.

Present: Senators Schmitt and Chiles.

Also present Senator Hayakawa.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SOCIAL SECURITY ADMINISTRATION

STATEMENT OF JOHN A SVAHN, COMMISSIONER OF SOCIAL SECURITY

ACCOMPANIED BY:

ANTHONY L. ITTEILAG, ACTING DEPUTY ASSISTANT SECRETARY, BUDGET

LINDA S. McMAHON, ASSOCIATE COMMISSIONER FOR FAMILY ASSISTANCE

PHILLIP N. HAWKES, DIRECTOR, OFFICE OF REFUGEE RESETTLEMENT

SUBCOMMITTEE PROCEDURE

Senator CHILES. Good morning. I am pleased to welcome Mr. John Svahn, the Social Security Administrator, as our witness this morning. The Commissioner will present and justify the administration's 1983 budget request for the Social Security Administration.

The Social Security Administration will spend almost $200 billion in 1983 of which $20 billion is subject to annual appropriations and about $180 billion is provided through trust funds.

The Social Security Administration has administrative responsibility not only for the social security payments to retirees and the disabled, but also for the SSI, aid to families with dependent children, low-income home energy assistance, and the refugee and entrant assistance programs. This morning's hearing will, therefore, cover a wide range of topics.

REFUGEE AND ENTRANT ASSISTANCE

It will not come as a surprise to the Commissioner that I have a particular interest in the refugee and entrant programs and so we'll spend a fair amount of time discussing those. I have a few criticisms of the administration's budget proposals for the Cuban/Haitian entrant program:

First, basing the budget implementation of your new 18-month limit on reimbursement for the non-AFDC cases discriminates against States like Florida which have no general assistance programs. While your decision to increase the amount of targeted assistance to heavily affected areas would soften the blow, it still leaves Florida on a very unequal footing.

Second, your $17.3 million 1983 request for the Cuban/Haitian domestic assistance program is woefully inadequate. If you repeated the higher amount of targeted assistance in 1983, we would be closer to the mark.

Third, your proposal to totally eliminate assistance to school districts with large numbers of refugees and entrants totally ignores a major social and physical impact in these communities.

In general, Commissioner, I think the administration is still failing to accept the fiscal responsibility for the hundreds of thousands of people who are here because of federal immigration policy. I have been an active participant in trying to cut back the overall level of Federal spending, but I think we have to be clear where we are really cutting costs and where policies are just shifting those costs to the State and local level.

Refugees are going to use local schools, they are going to use county hospitals, they require the cost of police, fire, sanitation. And once you make a Federal decision to let refugees in, they are going to concentrate in certain areas where a community or climate is something that they are comfortable with.

If you cut the Federal assistance, you don't hurt the refugees; you hurt the local taxpayer who is going to have to foot the bill for those schools and hospitals, for the policemen and the firemen and everything else.

Commissioner, we will ask you to summarize the long statement which you submitted for the record so that we can proceed to some questions. And I would like you to introduce your associates. And we welcome them to the hearing.

First, though, Senator Hayakawa has joined us. And I believe that he would like to make an opening statement at this time.

Senator Hayakawa, we welcome you to the committee.

ENGLISH LANGUAGE AMENDMENT

Senator HAYAKAWA. Thank you, Mr. Chairman.

Your statement and mine have many problems in common because between the two of us, we receive an awful lot of refugees from all parts of the world.

I think you will agree with me that the first duty of any immigrant is to learn the language of his new homeland. I have sought to encourage this practice by introducing Senate Joint Resolution 72, a constitutional amendment, which declares English as the official language of the United States. With this proposed amendment, I want to prevent a crisis similar, for example, to the separatist movement among French Canadians.

That confused state of affairs is the result of laws in Canada that provide for two official languages in that country, a fact which has become a source of damaging ethnic politics for many years.

I want to preserve the United States as one Nation indivisible, especially in the case of our common language.

Now, why I am speaking to you about my English language amendment is this: I believe it has a direct relationship to a matter which you will consider in this committee today—how to divide the limited Federal resources for refugee services.

EDUCATION OF REFUGEES

I am quite familiar with the work of the Office of Refugee Resettlement under its Director, Mr. Phillip Hawkes. I know that in fiscal year 1983, ORR, Office of Refugee Resettlement, under its Director, Mr. Phillip Hawkes, plans to provide refugee services through voluntary agencies, cash and medical assistance, social services, and preventive health. All these are admirable aims, but I do notice one thing missing, the immediate service that I believe should be given the highest priority: the education of refugee youngsters.

How are these children who have already been through great trauma going to learn English and become contributing members of our society without proper education, especially in the language of their new home?

I am here today to discuss the priorities we use in spending funds appropriated by Congress under the Refugee Act of 1980. I agree that all the services recommended are commendable, but especially due to your current Federal austerity in spending, we must make choices between what is good and what is best, what is helpful and what is essential.

I believe the transition program for refugee children is essential. I hope that before this hearing concludes, you will share my views.

I submit in the instances of Indochinese and other refugee children, not even a combination of Federal, State, and local education resources has provided enough materials and trained enough teachers since the inception of such Federal aid in 1975. I have observed this especially in my home State of California where one classroom may have as many as 30 different Indonesian dialects spoken by refugee children.

Local schools cannot predict the number of languages which will be spoken by Indochinese refugees in a given year. The schools need help in the initial phases of teaching English to such a variety of children speaking many native languages.

I wonder, Senator Chiles, if you have any similar problem in Florida.

Senator CHILES. Well, our problem is more the bilingual problem. We don't have as many of the dialects.

Senator HAYAKAWA. It is not as multilingual as we have.

Senator CHILES. It is not as multilingual.

Senator HAYAKAWA. Are we going to cripple the efforts of State and local schools which are going to educate a group of youngsters assigned to them through Federal immigration policies? Today, as I speak, there are approximately 170,000 refugee students who qualify for Federal aid under the transition program for refugee children. Under next year's reduced residency requirements, about 34 percent of refugee children in the United States 3 years or less will be eligible for Federal education assistance.

The Office of Refugee Resettlement has proposed eliminating this aid from the fiscal year 1983 spending plan for refugee services. That is eliminating this educational service.

I find it odd that no new money will be allocated to teach English to refugee children while local welfare departments will continue to be reimbursed for cash and medical assistance pay to refugees during their first 36 months in the United States.

ENGLISH LANGUAGE TRAINING

I would like to digress for a moment to point out that the language learning capacities of children are at their very height from the age of 2 to about 10, after which they decline. And none of us is as brilliant a student of language as we were when we were 6 years old. A child brought up in a trilingual family, for example, with father speaking one language, mother speaking another language, a housekeeper speaking a third language, will grow up trilingual without knowing he has gone through a complicated process. It just comes naturally.

But after the age of 16, it is an extremely difficult process to even learn one additional language. And we have all been through this.

What are our priorities? Is it to teach English to refugees so they can hold a job and get off of welfare or to keep them on public assistance by financing Federal handouts at the expense of English classes?

I encourage my colleagues on this committee as well as Secretary Schweiker, Commissioner Svahn, and the Office of Refugee Resettlement to reexamine our priorities for refugee services.

The first duty of an immigrant, Mr. Chairman, is to learn the language of his new homeland. And the Federal Government's first responsibility is to provide initial aid to the local schools which are teaching them English. Our Government brought the Indochinese refugees to this country as well as the Spanish-speaking refugees and the Haitians. We must see to it that they are properly equipped to become contributing members to our society.

If they do, they are a source of great cultural richness, cultural diversity, and, therefore, they will contribute to the creativity of our country. If they remain in linguistic ghettos, seething with discontent because they are not properly understood, because they don't speak English, they will be a source of trouble endlessly in the future.

I thank you, Mr. Chairman.

Senator CHILES. We thank you for your statement. And certainly from your experience, you speak with great authority and also, of course, understanding of the problems of your State. And I think it is so critical that we teach English. And that, of course, is one of the reasons that we feel strongly that some of the educational funds we have been providing for the refugee and entrant programs should be left in the budget as well as the social service funds.

Mr. Svahn, we will take your statement.

INTRODUCTION OF ASSOCIATES

Mr. SVAHN. Thank you, Mr. Chairman, Senator Hayakawa.

Let me introduce the people at the table with me. I have a feeling that one of them is going to be doing a considerable amount of speaking today.

On my left is Phillip Hawkes, the Director of the Office of Refugee Resettlement.

On my immediate right is Linda McMahon. Mrs. McMahon is the Associate Commissioner for Family Assistance in the Social Security Administration.

And to my far right is Mr. Itteilag who represents the Department of Health and Human Services.

As you indicated, Mr. Chairman, I would like to submit my prepared statement for the record and would just take a couple of minutes——

Senator CHILES. Thank you, sir.

Mr. SVAHN [continuing]. To briefly highlight our budget request for 1983.

I must say before that, Mr. Chairman, that I have been through five budget cycles in the State of California in State government and three prior to this in the Federal Government. I have been through three this past year, and I have found this to be an extremely confusing process.

SUMMARY OF BUDGET REQUESTS

Our budget for Social Security, which also includes at the present time the Office of Child Support Enforcement and the Office of Refugee Resettlement, requests for new budget authority for fiscal year 1983 $24.4 billion, which is an increase of $1.8 billion over fiscal year 1982.

As you pointed out, Mr. Chairman, this, of course, does not include funds used to pay benefits from the Old Age and Survivors Insurance and Disability Insurance Trust Funds which are permanently appropriated. We estimate in 1983, that these benefits will exceed $167 billion.

Two major changes, I think, Mr. Chairman, in the presentation of Social Security's 1983 budget request note comment.

The first is the change in appropriation structure. As I said, we also have in the past had in our assistance payments appropriation the funds for the Office of Child Support Enforcement. As you know, that is a separate agency. This year, we are requesting a separate appropriation for the child support enforcement program, and it will no longer be considered in the assistance payments appropriation.

We are also requesting a new appropriation, a combined welfare administration appropriation, which will provide grants to States for their administrative expenses in operating the AFDC, medicaid, and food stamp programs. The amount requested by Social Security relating to the AFDC program, which was previously in the assistance payments appropriation, and the medicaid program will be combined with the amount relating to the food stamp program which is being requested by the Department of Agriculture.

The second point, Mr. Chairman, and one that I found a little bit confusing, is that the budget estimates include proposed legislation. The assistance payments, SSI and the limitation on administrative expenses appropriation requests reflect the impact of proposed legislation.

The purpose of this type of presentation, which is a new technical requirement this year by the Office of Management and Budget, is to represent accurately the administration's request where that request differs from present law.

REQUEST FOR OFFICE OF REFUGEE RESETTLEMENT

The Office of Refugee Resettlement request is for $532,152,000. That includes cash and medical assistance and social services at $472 million, which is predicated on our estimate of 103,500 new refugees coming to this country in fiscal year 1983. And as you pointed out, Mr. Chairman, we have requested $17.3 million for the domestic assistance part of the Cuban/Haitian entrant program.

The other part, the reception and processing, will be in the Justice Department's budget.

I am pleased to announce today, Mr. Chairman, that the Vice President will announce that we will have in the Federal Register on Friday a program of special impact assistance to areas with high concentrations of entrants. And the amount of funds which we have proposed to put in that program will be increased to $35 million.

We have also proposed, and will have in the Federal Register on Friday a special $1 million project grant which will be used to resettle Cuban/Haitian entrants out of the South Florida area.

As you also pointed out, we have changed the——

Senator CHILES. Does this mean we are going to be able to close Krome?

Mr. SVAHN. Beg pardon?

Senator CHILES. Does this mean we are going to be able to close Krome?

Mr. SVAHN. No; we are talking about the Cuban/Haitian entrants. And the persons who are at the facility on Krome Avenue are persons who have come in since that time. And I don't believe that they technically qualify as entrants.

I have to ask Mr. Hawkes. I don't believe they technically qualify as entrants. They are detainees under the authority of the Immigration and Naturalization Service.

PREPARED STATEMENT

That is our summary, Mr. Chairman. We would be glad to answer any questions that you put forth.

[The statement follows:]

STATEMENT OF JOHN A. SVAHN

FY 1983 Appropriation Requests

Mr. Chairman and members of the Committee, I am pleased to be with you today to present the FY 1983 budget requests for the Social Security Administration, the Office of Child Support Enforcement and the Office of Refugee Resettlement. These requests total $24.4 billion in budget authority, an increase of $1.8 billion over FY 1982.

Summary of 1983 Budget Requests before the Committee

I would like to summarize for you the FY 1983 requests before your Committee that require appropriations action.

-- $855.2 million for Payments to Social Security Trust Funds. Through this account the trust funds are reimbursed for the costs of certain benefits and administrative expenses chargeable to Federal funds, such as benefits paid as a result of granting noncontributory credit for military service performed prior to the coverage of the armed forces under Social Security.

-- $1.1 billion for Special Benefits for Disabled Coal Miners. These funds cover benefit payments and administrative expenses for that portion of the black lung benefit program still administered by SSA.

-- $8.9 billion for the Supplemental Security Income Program. This request includes SSI benefits and reimbursement to the Social Security trust funds for the administrative costs of the SSI program.

-- $6.3 billion for the Assistance Payments Program. This appropriation includes the Federal share of the benefit costs of the Aid to Families with Dependent Children program and funds for Federal policy direction, technical assistance and guidance in the administration of the AFDC program.

-- $284.9 million for the Child Support Enforcement Program. This is a new appropriation to separate the Child Support Enforcement activities previously included as part of the assistance payments appropriation. It provides funds for Federal and State and local administration of the program to enforce the support obligations owed by absent parents to their children.

-- $1.7 billion for the new appropriation, Combined Welfare Administration. This appropriation is to provide grants to the States for their administrative expenses in operating the AFDC, Medicaid and food stamp programs. The amount requested by SSA includes only the administrative costs related to the AFDC and Medicaid programs. A separate appropriation of $526 million for the administrative costs of the food stamp program is being requested by the Department of Agriculture for a total of $2.2 billion.

-- $1.3 billion for Energy and Emergency Assistance. This provides funds for grants to States, Indian tribes, Puerto Rico and the territories for energy assistance to low income households, and also for emergency income maintenance and related needs. Federal administrative costs for these programs are included in the appropriation request.

-- $532.2 million for Refugee and Entrant Assistance. The Refugee Assistance program reimburses States for the costs of providing direct cash and medical assistance to needy refugees as well as English language training, vocational training and other social services, for the purpose of assimilating refugees into American society as quickly and effectively as possible. The Cuban-Haitian Entrant program reimburses States for the cost of assistance provided to certain Cuban and Haitian arrivals in the United States. Entrant assistance is comparable to that provided to refugees, and it is based on the provisions of title V of the Refugee Education Assistance Act of 1980. This appropriation request for FY 1983 assumes congressional reauthorization of the Refugee Act of 1980 which expires at the end of FY 1982.

-- $3.4 billion for the Limitation on Administrative Expenses. This request provides the funds needed to administer the old-age and survivors and disability insurance trust fund programs. It also includes funds to cover certain administrative costs of the Medicare program and administrative funds for the Supplemental Security Income Program, and several smaller programs. The trust funds are reimbursed for the administrative costs of the SSI and other non-trust fund programs through appropriations to other accounts.

Social Security Financing

Funds to pay benefits from the old-age and survivors insurance and disability insurance trust funds are permanently appropriated and therefore are not part of the budget request which I am here today to present. To put the Social Security system back on sound financial footing and restore public confidence in it, the President has established the National Commission on Social Security Reform. The Commission will prepare and submit to the President by December 31, 1982 legislative recommendations to ensure the current and long-term solvency of the Social Security trust funds.

Proposed Legislation Included in Budget Estimates

I also want to point out that the Assistance Payments Program, Child Support Enforcement Program, Supplemental Security Income Program and Limitiation on Administrative Expenses budget requests reflect the impact of proposed legislation. The purpose of this presentation is to represent accurately the Administration's request for these programs where that request differs from present law.

Agency Initiatives

Now I would like to report briefly on some of the initiatives I have undertaken during my brief, one-year stewardship of this Agency:

-- Debt Collection: We have implemented an action plan to do a better job of collecting benefit overpayments and other debts owed the trust fund and Federal funds. The new initiative is expected to save about $500 million in FY 1983 over the level of collections that would be produced in FY 1983 under the debt collection policy that was in effect in FY 1981.

-- Disability Program: We are implementing the Social Security Disability Amendments of 1980 by tightening-up the "front end" of the disability process through pre-effectuation review of a percentage of disability allowances, and by more closely monitoring continuing eligibility through periodic review of disability beneficiaries on the rolls. These two activities are estimated to save about $822 million in benefit dollars in FY 1983 that otherwise would be paid to people not eligible under the law.

-- Systems: Since assuming office as Commissioner of the Social Security Administration, improving SSA's automatic data processing systems has been my number one administrative priority. I recently released a comprehensive five-year systems modernization plan to deal with the Agency's serious systems problems. The FY 1983 budget request for the Limitation on Administrative Expenses includes $143 million for ADP and telecommunications equipment, supplies and contractual services--an increase of $19 million over the level budgeted for FY 1982. These estimates were prepared before the plan was developed.

-- Field Space: The Social Security Administration, the Department of Health and Human Services and the General Services Administration are working together in special teams to clear up SSA's pending backlog of field space requests by October 1, 1982 and to fulfill new requests for space within 190 to 265 days so that such a backlog will not develop again. The number of pending requests for improved or expansion space dropped by 51 (from 493 to 442) during the period October through December 1981.

-- Implementation of the Omnibus Budget Reconciliation Act of 1981: Implementation of the major OASI, DI, and SSI provisions of the law is on schedule, and the budget includes benefit savings of about $2.6 billion dollars in FY 1983 as a result of them. The OASDI provision producing the greatest savings in FY 1983 is the phase-out of postsecondary students benefits, which we estimate will save about $1.5 billion in that year alone. The budget also includes benefit savings of about $1.2 billion dollars in FY 1983 as a result of the AFDC and child support enforcement provisions of this legislation. Most of these savings result from provisions which change the way that income is counted for purposes of determining AFDC eligibility and calculating AFDC benefits.

Administrative Resources Budgeted

Finally I want to tell you about the level of administrative resources we need to carry out the Agency's major initiatives.

The President's requests for the Limitation on Administrative Expenses for FY 1982 and FY 1983 include sufficient resources to carry out the initiatives, such as debt collection and reform of the disability programs, planned for the OASI, DI and SSI programs. This includes a supplemental appropriation request for $42.9 million in FY 1982. Likewise our administrative budget requests for the AFDC and Child Support Enforcement Programs contain the resources we need to carry out program cost-savings initiatives, such as those contained in the Omnibus Budget Reconciliation Act of 1981. However, in order to provide necessary Federal administrative resources in FY 1982 to promote State progress in implementing cost-savings initiatives, we are requesting reprogramming of about $7 million from AFDC benefit payments to Federal administration.

I request your assistance in obtaining congressional approval for FY 1982 of the reprogramming request in the assistance payments account and the supplemental request for the Limitation on Administrative Expenses account to ensure that the Agency has sufficient administrative resources to carry out initiatives to save program dollars in both FY 1982 and FY 1983.

Payments to Social Security Trust Funds

The first appropriation request totals $855,213,000 and covers three Federal fund payments to the Social Security trust funds. The payments are necessary to make the trust funds whole for the cost of certain benefits, or administrative expenses, borne by the trust funds initially but ultimately chargeable to Federal funds. The three payments cover the following:

1. Reimbursement to the OASI and DI trust funds for the costs of benefits paid as a result of granting Social Security credits for certain earnings from military service on which servicemen were not required to pay Social Security taxes.
2. Reimbursement to the OASI trust fund for benefits paid to certain elderly persons aged 72 or older who did not have a chance to work long enough under Social Security to become insured, but were allowed special benefits.
3. Reimbursement to the OASI trust fund for the administrative costs incurred by the Social Security Administration in maintaining records of the vested pension rights of individuals in private pension plans and in advising these individuals of these rights.

In all three cases the reimbursement is necessary to insure that the trust funds, built up by the Social Security taxes paid by workers and employers, are not reduced for benefits to the uninsured or by administrative expenses not applicable to Social Security programs.

Military Service Credits

The first of the three payments is a reimbursement of $715,807,000 to the Old-Age and Survivors Insurance and Disability Insurance Trust Funds for non-contributory military service credits. It includes a $617,000,000 annual installment related to military service during World War II and prior to 1957 when servicemen began receiving regular coverage under Social Security.

The remaining $98,807,000 is for estimated benefit payments based on non-contributory credits for wages-in-kind--such as food, shelter and medical services--which have been granted to members of the Armed Forces since 1957.

Special Payments to Certain Uninsured Elderly Persons

The second payment of $138,662,000 is to reimburse the Old-Age and Survivors Insurance Trust Fund for special benefits paid during FY 1981 to certain uninsured persons aged 72 years and over. These persons, a declining population, were not eligible for regular monthly Social Security benefits primarily because they retired before enactment of Social Security legislation or before their occupation was covered under Social Security.

As of September 30, 1981, 77,000 persons were receiving benefits chargeable to the general funds under this provision as compared to 94,000 a year earlier. Benefit payments are currently $117.000 for an individual and $58.50 for an eligible spouse. These benefits are expected to increase to $126.00 and $63.00 respectively in June 1982 based on the projected increase of 8.1 percent in the automatic cost-of-living adjustment. In June 1983 the comparable benefits are expected to increase to $134.00 and $67.00 respectively based on a 6.5 percent automatic adjustment.

Reimbursement for Pension Reform Administrative Cost

The third payment of $744,000 is to reimburse the Old-Age and Survivors Insurance Trust Fund for the Federal funds share of the cost of administering pension reform responsibilities assigned to the Social Security Administration under Public Law 93-406, the Pension Reform Act. The reimbursement is for the cost of furnishing information on deferred vested pension rights to pension plan participants or their survivors.

Explanation of Change for FY 1983 Request

The total request for FY 1983 is $10,515,000 more than the FY 1982 appropriation. This amount is the net result of an increase in the payments of military service credits partially offset by decreases in special payments for certain uninsured persons and pension reform.

The amount requested for non-contributory military service credits is $13,264,000 higher than the FY 1982 level. This increase is due to a larger number of beneficiaries and higher benefit amounts relating to post-1956 military wage credits. The annual installment for pre-1957 service credits remains unchanged.

The special payments for certain uninsured persons and pension reform requests account for decreases of $1,745,000 and $1,004,000 respectively. The population receiving special payments is a closed group of very aged, uninsured persons and, thus, becomes smaller every year. The reimbursement for pension reform administrative costs have been reestimated to reflect workloads that have been smaller than expected.

Special Benefits for Disabled Coal Miners

This appropriation request for Special Benefits for Disabled Coal Miners totals $1,102,000,000 and is financed from general revenues. It includes $1,095,000,000 for benefit payments and $7,000,000 for administrative costs. It does not include reimbursable work done for the Department of Labor, which is budgeted for by that agency.

Program Authorization

The Black Lung program is authorized by title IV of the Federal Mine Safety and Health Act of 1977, which provides for payment of monthly cash benefits to coal miners who are totally disabled because of pneumoconiosis, commonly referred to as black lung disease, and to widows of miners who were entitled to these benefits or whose deaths were due to this disease. Payments to miners or widows are increased for dependents--a spouse or child. Benefits also are payable to surviving children of miners and in certain circumstances to totally dependent surviving parents, brothers, and sisters.

Responsibility for Administration

The Social Security Administration is responsible for processing and paying claims for miners' benefits filed from December 30, 1969, through June 30, 1973, and claims for survivor benefits filed through December 31, 1973, or within 6 months after the death of a miner or widow already on the beneficiary roll maintained by SSA. SSA must continue to pay benefits and to maintain the beneficiary roll for the lifetime of all persons who filed with SSA during its jurisdiction.

Since June 30, 1973, SSA has continued to take miners' claims, but as an agent of the Department of Labor, which is responsible for adjudication and payment of these claims, and thus budgets to reimburse SSA for this work.

The beneficiary roll for which SSA has responsibility will continue to decline gradually in years to come. At the mid-point of fiscal year 1983, 355,000 miners, widows, and dependents will be receiving monthly benefits paid by the Social Security Administration from this appropriation. This is a decrease of 19,000 from the 374,000 beneficiaries who will be receiving payments at the mid-point of fiscal year 1982.

1983 Request

We expect benefit payment obligations to be $1,095,000,000 in 1983--$2,535,000 more than in 1982. The budget projects a 5.0 percent benefit increase effective October 1982, which will raise benefit payments by $48,535,000. This increase is partially offset by a reduction of $45,000,000 for the decreasing number of black lung beneficiaries, and by $1,000,000 because the number of black lung claims with retroactive payments is dropping off, as cases under appeal are settled.

Our budget request of $7,000,000 for 1983 black lung administrative expenses is $700,000 higher than the level estimated for FY 1982. This is due in part to a 5.0 percent Federal pay increase assumed to be effective in October 1982, at an estimated cost of $300,000.

The remaining increase--$400,000--has been budgeted in anticipation of costs associated with carrying out SSA's corrective action plan to purge the benefit rolls of ineligible beneficiaries. As the Secretary previously advised the Committee in his letter of December 1, 1981, a recent cross-check which matched social security records against the Black Lung beneficiary rolls indicated that Black Lung benefit checks were being sent inadvertently to a number of recipients who had died or who had become ineligible due to divorce. I consider it a high priority for SSA to carry out a rigorous plan of corrective action to identify ineligibles and purge them from the rolls, in order to prevent future incorrect payments, as well as to proceed where possible to recover incorrect payments which already have been made.

Supplemental Security Income Program

The Supplemental Security Income (SSI) appropriation provides funds through direct cash assistance to eligible aged, blind and disabled recipients to help finance their basic needs. The appropriation request for FY 1983 is $8,919,495,000. This includes $8,012,471,000 for Federal benefits to aged, blind and disabled recipients; $15,962,000 for hold-harmless payments; $4,616,000 for beneficiary rehabilitation services; $863,709,000 for administrative costs; $20,737,000 for reimbursing States for incorrect State supplementary payments made as a result of Federal errors; and $2,000,000 for SSI demonstration projects.

The appropriation request for FY 1983 reflects projected savings of $334,000,000 from new legislation: the SSI entitlement reforms proposed by the President. These reforms, which require action by substantive committees of Congress, provide for the proration of the first month's SSI benefit based upon the date of application; the rounding of the SSI payment standard and benefit amount to the next lower dollar; a change in the definition of permanent disability to a prognosis of at least 24 months of disability and a preponderance of medical rather than other factors; the elimination of the $20 disregard for new recipients; and the recovery of SSI overpayments to individuals from available Social Security benefits.

Federal Benefit Payments

The SSI program ensures a minimum monthly level of income to eligible aged, blind and disabled individuals. An individual's income, resources and living arrangements are evaluated to determine the actual amount of SSI payment. Payments are delivered through monthly benefit checks.

The FY 1983 request for Federal benefit payments is $8,012,471,000 or $1,041,471,000 higher than the FY 1982 level. This increase includes $645,000,000 for the October 1, 1983 payment which, since it falls on a Saturday when banks are closed, will by law have to be made in FY 1983, rather than in FY 1984. The result is that FY 1983 will include payments for 13 months and FY 1984 will only include 11 payments. A variety of other factors account for the increase over the FY 1982 level. The main factor is the yearly automatic cost-of-living adjustment (COLA). Under present law, the maximum monthly SSI payments are projected to increase automatically by 8.1 percent in July 1982 and 6.5 percent in July 1983. This will raise the monthly maximum for July 1983 to $304.90 for an individual and $457.10 for a couple in comparison with a monthly maximum in July 1981 of $264.70 for an individual and $397.00 for a couple.

In FY 1982 the estimated average payment (the maximum payment adjusted for an individual's income and living arrangements) is $119.33 for an aged individual and $193.10 for a blind or disabled individual. These are projected to increase in FY 1983 to $138.48 and $226.51 respectively, due primarily to the COLA.

The increases would be higher except for the following factors:

--SSA's initiatives to improve payment accuracy by locating and terminating ineligible recipients and correcting payments to eligible recipients. A number of initiatives are in place or planned to improve the quality of disability determinations, insure stricter development, identify error prone cases and verify entitlement through special validations against records of financial institutions and other Federal and State programs.

--Increases in Social Security benefits due to COLA reduce average SSI payments. Roughly half of the SSI recipient population also receive title II benefit payments, and their SSI benefits must be reduced as their income from other sources increases.

Hold-Harmless Payments to States

The hold-harmless provision, included in the original SSI legislation (P.L. 92-603), provided for the Federal Government to assume liability for certain State supplementation payments made to raise the total assistance up to the level received by the recipients prior to the SSI program. This provision was intended as a means of limiting a State's supplementary payment costs in the event that large numbers of new recipients were brought on to the rolls by the transition to SSI. All States but three (Wisconsin, Massachusetts and Hawaii) lost their eligiblity for this program because their costs for supplementary payments subject to hold-harmless protection diminished as a result of the rising Federal benefit level. However, in 1976 an amendment (P.L. 94-585) to the original legislation provided for disregarding increases in Federal SSI payments in computing payments protected by the hold-harmless provision. By this means a transitional program was turned into an open-ended one for a few States.

In FY 1983 the Administration proposes to continue the phase-out of hold-harmless payments by means of the SSI appropriation language which was agreed to by Congress in its action on the third Continuing Resolution for FY 1982. Substantive legislation also is being proposed. The phase-out is based on 60 percent of costs under the current legislation in FY 1982, 40 percent of such costs in FY 1983, 20 percent of these costs in FY 1984 and the complete phase-out of the program in FY 1985. We anticipate that two States will still qualify for this program in FY 1982 and FY 1983--Wisconsin and Hawaii. Of the total appropriation request in FY 1983, 99.8 percent is for Wisconsin.

Beneficiary Rehabilitation Services

As a result of the Omnibus Budget Reconciliation Act of 1981, SSA will provide funds only to reimburse vocational rehabilitation agencies for costs incurred in successfully rehabilitating SSI recipients. It is anticipated that State vocational rehabilitation agencies will take on fewer difficult cases because of the restrictive definition of success and the likelihood that reimbursement will be less certain. Based on this change in law, we estimate that $3,000,000 will be required for vocational rehabilitation in FY 1983. In addition, we are requesting $1,616,000 for the referral and monitoring of SSI recipients who are drug addicts and alcoholics--the same level of funding provided for this activity in FY 1982.

Payments to Trust Funds for Administrative Costs

The SSI and Social Security programs are administered on an integrated basis for purposes of economy and efficiency. The Social Security Act authorizes advances from the Social Security trust funds to pay the administrative costs of the SSI program through the Limitation on Administrative Expenses. The advances are fully repaid from the SSI appropriation. SSA maintains a detailed cost allocation system which has been audited by the General Accounting Office to ensure that the trust funds are made whole (with interest, if appropriate) for the administrative expenses of the SSI program. The FY 1983 request for this activity is $863,709,000 which represents a $98,829,000 increase over FY 1982.

Federal Fiscal Liability

The Social Security Administration administers supplemental payments for 26 States and the District of Columbia. Agreements with the States governing Federal administration of these State supplementary payments provide for Federal fiscal liability (FFL) for payment errors in excess of a 4 percent tolerance. The FY 1983 budget assumes that we will be able to continue to carry over any unobligated balances of FFL budget authority, with these balances remaining available exclusively for FFL. Experience has shown that the timing of FFL settlements is difficult to predict since they are dependent on negotiated settlements with States. Therefore, the carry-over is necessary. We expect an unobligated balance of prior year budget authority of $6,483,000 to be available in FY 1983 in addition to the $20,737,000 new budget authority that we are requesting. The total of $27,220,000 will be used to cover settlements for the period October 1981-September 1982. We expect to obligate $45,551,000 in FY 1982 for all settlement periods prior to October 1981.

Demonstration Projects

The Social Security Disability Amendments of 1980 (P.L. 96-265) authorize waiver of certain provisions of the Social Security Act in order to conduct demonstration projects likely to assist in promoting the objectives or facilitating the administration of the SSI program. We are requesting $2,000,000 in FY 1983, our first request under this authority, in order to carry out such demonstration projects which will assist the SSI program. The demonstration projects being considered would provide an evaluation of monthly reporting and other factors critical to computing SSI benefits on a monthly basis, provide the information needed to properly evaluate current alcoholic and drug addiction programs in order to determine the best approach in preventing the onset of irreversible medical conditions which may result in permanent disability, and to determine the best methods by which mentally retarded recipients can make the transition to work. The major objective of these demonstration projects is to find ways to use scarce program and administrative dollars more effectively.

Assistance Payments

This appropriation finances the Assistance Payments program which provides funds through grants to States and local governments for diverse activities related to public assistance to the needy. Although the Social Security Administration is responsible for the programs covered by this appropriation, no trust fund money is used for assistance payments purposes. For fiscal year 1983 the Assistance Payments request, which includes assumed savings from proposed legislation, is $6,305,976,000. The total appropriation for FY 1983 is the sum of the regular appropriation requested at this time ($4,518,635,000) and the advance appropriation for the first quarter of FY 1983 previously enacted ($1,787,341,000). The total request includes $5.42 billion for maintenance assistance, which includes Aid to Families with Dependent Children and related programs; $2.95 million for research and evaluation; $32 million for Federal administrative expenses; $728.7 million to replace funds borrowed from fiscal year 1983 to cover the funding shortfall in fiscal year 1982; and $123.5 million to be transferred from the FY 1983 advance appropriation already approved to the new separate child support enforcement appropriation.

At this time, we are also requesting an advance appropriation of $1,327,203,000, which includes assumed savings from proposed legislation, to fund first quarter FY 1984 grants. This advance appropriation is the mechanism, which replaced "borrowing" authority, for providing funds to the current year for issuing first quarter advance grants for the next fiscal year. The mechanism protects the States from gaps in funding and enables them to plan in advance for first quarter operations.

Several major changes in the method of presenting the budget may cause some difficulty in understanding the year-to-year change in the Assistance Payments appropriation. First, these requests include three major changes in appropriation structure that affect Assistance Payments:

--We want to move Child Support Enforcement program costs--including State and local administration, research and evaluation, and Federal administration--to a new separate appropriation. Child support collections, however, would remain in Assistance Payments as an offset to AFDC benefits. The purpose of these changes is to give recognition to the independent status of the Office of Child Support Enforcement. The discussion of year-to-year changes in child support costs is in the Child Support Enforcement statement.

--We want to move costs for State and local administration and training for the maintenance assistance activities in the 50 States and the District of Columbia to a Combined Welfare

Administration account which will also fund the State and local administrative costs of the Medicaid and food stamps programs. The purposes of this change are better control of State and local administrative costs and increased flexibility to the States. The transfer of these activities reduces the Assistance Payments request by $901,094,000 from the FY 1982 level.

--We want to move the Emergency Assistance program and consolidate it with the Low Income Home Energy Assistance program in a new Energy and Emergency Assistance account. The purpose of the consolidation is to increase cost effectiveness and eliminate duplicative administrative mechanisms. This change results in a $60,700,000 decrease from the FY 1982 level for Assistance Payments.

Second, the FY 1982 and 1983 estimates shown in the 1983 budget include savings from legislation proposed for enactment in FY 1982. The savings assumed in the estimates are $166 million in FY 1982 and $1,095 million in FY 1983.

After taking into account the proposed changes in appropriations structure and excluding the impact of the new legislation included in the estimates, the total Assistance Payments appropriation request for 1983 is about $321 million less than the 1982 level for the same activities.

Maintenance Assistance

The fiscal year 1983 request for the Federal share for the maintenance assistance activities, which remain after the structural changes just mentioned, is $5,418,867,000. The request includes:

--$5,397,000,000 for Aid to Families with Dependent Children (including a reduction for offsetting child support collections of $353,000,000).

--$13,350,000 for assistance to aged, blind and disabled adults in Puerto Rico, Guam and the Virgin Islands; the Supplemental Security Income program does not cover these jurisdictions.

--$6,716,000 for administration and training costs in Puerto Rico, Guam and the Virgin Islands. The costs for these activities in the three jurisdictions were excluded from the transfer of State and local administration and training to the Combined Welfare Administration account.

--$1,801,000 for assistance to repatriated U.S. Nationals returning from foreign countries who have been certified by the Department of State as destitute or ill.

The 1983 request for these maintenance assistance activities is $1,252,542,000 lower than the 1982 level for the same activities. This decrease is the net result of several factors of decrease and increase, but the major change is a decrease of $1,253,000,000 in AFDC benefits. Significant decreases in the Federal share of AFDC benefits result from the following factors:

--A decrease of $384 million from the 1982 level as a result of greater savings from the AFDC provisions in the Omnibus Budget Reconciliation Act of 1981. The decrease results primarily from the effect of full-year savings for the mandatory provisions and increased State participation in the optional provisions in 1983.

--A decrease of $929 million from the 1982 level as a result of savings from legislation proposed for enactment in FY 1982. The proposals, which require action by the legislative committees, are designed to strengthen AFDC employment incentives, determine AFDC benefits by including in the applicant's income those resources which are often available to an AFDC family but have not been counted previously, eliminate program overlaps and simplify program administration, and encourage States to run the AFDC program more efficiently by phasing in full State fiscal responsibility for erroneous AFDC payments beginning with 3 percent in FY 1983 and reaching zero percent by FY 1986.

--Savings of $31 million resulting from a projected reduction in States' payment error rates from 7.3 percent in FY 1982 to 6.8 percent in FY 1983.

--Savings of $93 million for imposition of fiscal sanctions, under present law, for projection of error rates which exceed the Michel Amendment error rate targets in the FY 1982 reporting periods. The budget projection of the sanction amounts is based on national average error rate trends, not on projections of specific State error rates.

The major increases in AFDC benefits, which total $190 million, result from economic and demographic factors including: an increase in average benefits, due to both inflation and increases in State standards of need; an increase in the number of families headed by females, the major source for the AFDC caseload; and an offsetting decrease in the unemployment rate.

Research and Evaluation

We are requesting $2,950,000 for research and evaluation grants and contracts under sections 1110 and 1115 of the Social Security Act to finance experimental projects to evaluate the best techniques for achieving successful community work experience (workfare) programs, develop better ways to detect incorrect welfare payments, and improve the management and effectiveness of State welfare programs.

Of these funds, $375,000 will be used to continue certain research projects and $2,575,000 will be used to fund new projects. Most of the money is for research and demonstration projects related to the AFDC program, but some of the funds are used for Social Security and SSI extramural research grants and contracts.

Federal Administrative Expenses

In 1982, a reprogramming of $4,813,000 has been proposed primarily to provide this account with the Federal administrative resources necessary to achieve as much of the savings as possible from the provisions of the Omnibus Budget Reconciliation Act of 1981. In 1982 after reprogramming, this account will have $30,813,000 and 757 full-time permanent positions.

The 1983 request includes $32,000,000, an increase of $1,187,000 over the 1982 level after reprogramming, and 757 full-time permanent positions, the same number as in 1982 after reprogramming. The increase of $1,187,000 is necessary to cover mandatory costs such as the costs of the full-year effect of the October 1981 pay raise, within-grade raises and promotions. The 1983 request provides the resources necessary to continue the efforts, at the 1982 level, to achieve the Reconciliation Act savings.

Funding of FY 1982 Shortfall

The 1983 request includes $728,659,000 to replace funds borrowed from FY 1983 to cover a funding shortfall in FY 1982. This amount is already net of $201,000,000 in assumed savings from legislative proposals that have a FY 1982 impact. Without the enactment of those proposals the shortfall borrowing would be $929,659,000. The shortfall in FY 1982 results from changes in several factors including higher-than-projected unemployment levels and increases in inflation, a higher-than-anticipated number of families headed by females, and lower-than-estimated savings in 1982 from the Omnibus Budget Reconciliation Act of 1981.

Child Support Enforcement

Although a separate appropriation has been requested in FY 1983 for child support enforcement, the FY 1983 advance appropriation for Assistance Payments contained $123,500,000 for child support State and local administrative costs for the first quarter of FY 1983. These funds will be transferred to the new appropriation for use in FY 1983. The separate child support appropriation request for FY 1983 was reduced by $123,500,000 to reflect the transfer from this Assistance Payments appropriation.

Child Support Enforcement

We are proposing a new appropriation to fund the Child Support Enforcement Program activities previously contained in the Assistance Payments Program. A separate appropriation is being proposed in recognition that the Office of Child Support Enforcement (OCSE) is an independent agency and not part of the Social Security Administration. The new appropriation would provide funds through grants to States to enable them to assist families by locating absent parents, establishing paternity, obtaining child support orders and enforcing the support obligations owed by absent parents to their children. The Federal matching share of State and local administrative costs, Federal administrative costs, and research and evaluation funds applicable to child support enforcement will be included in this new appropriation. Child support enforcement collections related to the AFDC program will continue to appear in the Assistance Payments Program account as an offset to AFDC benefit costs. The FY 1983 budget request is for $284,877,000. However, last year Congress appropriated $123,500,000 for the Child Support Enforcement Program as part of the FY 1983 first quarter advance appropriation for the Assistance Payments Program. Therefore, the total 1983 appropriation for child support is $408,377,000. This includes $387 million for the Federal share of State and local administrative costs, $20.9 million for Federal administrative expenses and $450,000 for research and evaluation.

Advance Appropriation

At this time we also are requesting an advance appropriation of $112,500,000 to fund first quarter FY 1984 grants. Consistent with the approach adopted last year in the Assistance Payments Program appropriation, the advance appropriation will provide funds in FY 1983 for issuing first quarter advance grants for the first quarter of FY 1984. Such a procedure enables States to continue program operations without interruption and to plan in advance.

Proposed Legislation

As in all other accounts in the President's FY 1983 budget, the appropriation request for FY 1983 reflects projected savings from new legislation ($145 million for this account). The proposed reforms, which require action by legislative committees of Congress, will strengthen the child support program by relating program financing more directly to performance, stimulating increased collections, and improve cost effectiveness, and recovering costs incurred in the provision of child support services to families not receiving AFDC benefits. The request for the FY 1984 advance appropriation reflects savings of $37,750,000 from these legislative proposals.

State and Local Administrative Costs

The FY 1983 request for the Federal share of State and local administrative activities ($387 million) is a $68 million decrease from the FY 1982 level. This decrease is contingent upon congressional passage of the President's proposed child support legislation which is projected to save $145 million in the Federal share of State and local administrative costs in FY 1983 ($35 million in FY 1982). Without enactment of these proposals, the Federal share of these costs will increase by $42 million over FY 1982. This increase reflects the increased caseload for both AFDC and non-AFDC cases, and the higher costs per case due to inflation.

Research and Evaluation

We are requesting $450,000 for research and evaluation grants and contracts under section 1110 of the Social Security Act. These funds will be used primarily to analyze and evaluate new administrative techniques to increase the number of cases where full and regular child support collections are received.

Federal Administrative Expenses

In FY 1982 a reprogramming of $2,427,000 has been proposed primarily to provide this account with the Federal administrative resources necessary to achieve as much of the savings as possible from the provisions of the Omnibus Budget Reconciliation Act of 1981. In FY 1982 after reprogramming, this account will have $19,927,000 and 359 full-time permanent positions.

The FY 1983 request includes $19,927,000, an increase of $1,000,000 over the FY 1982 level after reprogramming, and 359 full-time permanent positions, the same number as in FY 1982 after reprogramming, to enable the Office of Child Support Enforcement to provide policy direction, technical assistance and guidance to State and local child support enforcement programs in addition to its monitoring and grants management functions. The increase of

$1,000,000 is necessary to cover mandatory costs such as the costs of the full-year effect of the October 1981 pay raise, within-grade raises and promotions. The FY 1983 request provides the resources necessary to continue the efforts, at the FY 1982 level, to achieve the Reconciliation Act savings.

The Office of Child Support Enforcement also performs reimbursable work ($550,000 and 2 work-years) for the States. This activity is authorized by the Federal Parent Kidnapping Act of 1980 (P.L. 96-211) which allows use of the Federal Parent Locator Service to locate parents with custody of a child in violation of a court order.

Combined Welfare Administration

The Combined Welfare Administration Appropriation is to provide funds through block grants to the States for State and local administrative costs of the food stamps, Medicaid and AFDC programs. These amounts will be provided in a single payment and will be capped at 95 percent of the Federal share of ongoing FY 1982 administrative expenses for these programs. For FY 1983 the SSA request for this account, which covers only the State and local administrative costs of the AFDC and Medicaid programs, is for $1,655,000,000. In addition, $526,000,000 will be requested by the Department of Agriculture for food stamp administration--for total budget authority of $2,181,000,000.

The new account will combine functions previously funded from three separate appropriations: the State administration activity of the Food Stamp Program appropriation; the State and local administration activity of the Grants to States for Medicaid appropriation; and the State and local administration and training activities of the Assistance Payments Program appropriation. State and local administrative expense activities, which are now open-ended matching programs, will be capped in a single payment with no State match required. Many Federal administrative requirements will be reduced or eliminated to give States added flexibility. By receiving greater responsibility for running these programs, States will have the opportunity to design more efficient mechanisms that best serve beneficiaries and hold down administrative costs.

Some categories of State and local administrative expenses, such as food stamp antifraud and antiabuse activities, have been matched at a higher rate by the Federal Government. The Federal Government will continue to match, from other appropriations, those fraud and abuse activities on an open-ended basis. This reflects the high priority given these programs. Also, this new combined welfare administrative appropriation does not include funds for the administrative and training costs for welfare programs in Puerto Rico, Guam, and the Virgin Islands. These costs will continue to be funded from the respective appropriations.

Energy and Emergency Assistance

At present, States through two separate grant programs administered by the Office of Family Assistance in SSA, assist low income households with high home energy costs, or households in need of emergency financial aid or other crisis support. For FY 1983 a new appropriation is proposed to consolidate energy and emergency assistance activities under one program. The FY 1983 budget request is for $1.3 billion for this purpose. This includes $1,297,800,000 for grants to States and $2,200,000 for Federal administrative expenses.

The proposed energy and emergency block grant will provide the States with increased flexibility to meet the needs of their citizens. The new block grant will enable States to provide financial assistance for energy needs to low income households as well as emergency medical care, social services and other forms of emergency assistance. Previously emergency assistance activities were provided to States through categorical grants in the Assistance Payments Program account. Not all States took advantage of the emergency assistance grants because of red tape and matching requirements. Under the new energy and emergency block grants, restrictive Federal regulations and requirements will be reduced significantly. This new approach will eliminate overlapping planning, administrative and reporting procedures. Federal budget savings will result since the emergency assistance activities will be funded at a reduced level.

The FY 1983 request includes $2,200,000 and 40 work-years for Federal administrative costs. This is a 27 percent reduction from the 1982 level in administrative costs and assumes passage of proposed legislation designed to further simplify the program and reduce the level of Federal involvement. The need for Federal technical assistance is also expected to be less due to the nature of the new program.

The legislative proposals which the Administration is developing will futher simplify the program and increase State flexibility in addition to combining energy and emergency assistance activities. Proposals are being developed which will remove many of the Federal requirements which currently restrict the States' abilities to determine the particular needs of their jurisdictions. These proposals are currently being drafted and will be submitted to the legislative committees.

Finally we wish to report to the Congress that the Administration is moving rapidly in response to the recently enacted $123,000,000 emergency energy supplemental. SSA has distributed funds to all the States in accordance with the Congressional direction to distirbute the funds within 15 days of enactment.

Limitation on Administrative Expenses

The Limitation on Administrative Expenses is a request for authority to spend up to $3,408,451,000 from the trust funds for the FY 1983 administrative expenses of the Social Security Administration.

This account funds administration of the old-age and survivors and disability insurance programs, Medicare work performed by SSA, and the construction needs of the Social Security trust fund programs. In addition, because SSA administers both trust fund and nontrust fund programs on an integrated basis for purposes of economy and efficiency, the law authorizes payment of certain other administrative expenses from this account, with later full reimbursement from general funds. The nontrust fund work handled in this way includes work relating to the Supplemental Security Income Program, work associated with the Pension Reform Act of 1974, and the portion of annual wage reporting work done by SSA for the benefit of the Internal Revenue Service.

Of the new budget authority requested:

--$1.1 billion is for administering the old-age and survivors insurance program,
--$1.2 billion is for the disability insurance program,
--$124.9 million is for SSA's Medicare support functions,
--$863.7 million is for administering the SSI program,
--$64.3 million is for processing annual reports of earnings,
--$0.7 million is for pension reform responsibilities,
--$56.0 million is for SSA's construction needs, and
--$50.0 million is for the contingency reserve, which provides funds to SSA only if workloads and certain specified costs exceed the budget estimates.

Budget Emphases for FY 1982 and FY 1983

SSA's administrative budget request reflects three general areas of emphasis in fiscal years 1982 and 1983.

1. Invest Administrative Resources to Save Program Dollars

SSA's budget includes initiatives which reflect the theme of requesting administrative resources where there is good potential for greater savings in program dollars. I have emphasized this theme in my general opening statement, which covers all SSA accounts in the budget. The key areas are improved administration of the disability program (to prevent erroneous payments) and improved debt collection, especially when overpayments of benefits occur. The administrative budget request for these disability initiatives totals $177 million in FY 1982 and $295 million in FY 1983. However, we estimate that benefit savings of $431 million in FY 1982 and $822 million in FY 1983 will result. SSA's stepped-up debt collection initiative is expected to save an additional $250 million in FY 1982 and $460 million in FY 1983 in the OASI, DI and SSI programs.

2. Reduce Work of Lesser Priority

Another key theme of this budget request is to reduce resources for non-essential work and to look for ways to save work-years. SSA's budget for FY 1983 reflects policy changes in four areas which will save about 2,150 work-years and $56 million annually. For example we have begun to defer development of nonmedical factors of entitlement in disability claims until after a favorable disability decision is rendered. This will save work-years expended unnecessarily in developing nondisability factors of entitlement in claims later denied for medical reasons. Also, we propose to maintain pre-effectuation review of disability allowances (authorized by the 1980 Disability Amendments) at 35 percent in FY 1983 rather than increase to 65 percent as provided in the law, until we have a better idea about what level of review is cost effective. Legislation or appropriations waiver language is required to maintain 35 percent pre-effectuation review in FY 1983.

The FY 1983 budget estimate includes additional savings of $49.4 million related to reducing certain administrative activities which we believe are of lesser priority and should be curtailed in order to conserve scarce administrative resources. We also are requesting legislation or appropriations waiver language to relieve SSA of these requirements to:

--provide additional data to "personalize" disability denial notices,
--pay for claimants' cost of medical evidence of record in support of their disability insurance claims, and
--provide the free service to the legal community of setting reasonable attorney fees and deducting these fees from benefit payments.

In addition to these SSA-initiated changes, implementation of the OASDI and SSI provisions of the Omnibus Budget Reconciliation Act of 1981 reduce SSA's FY 1983 administrative budget by about 900 work-years and $13.7 million.

3. Deal with Problem Areas

I want to tell you how this budget request deals with two problem areas:

Systems: I recently released a comprehensive five-year systems modernization plan to deal with the Agency's serious systems problems. The FY 1983 request for this account includes $143 million for ADP and telecommunications expenses, an increase of $19 million over the level budgeted for FY 1982 and more than double the amount budgeted for FY 1981. These estimates were prepared before the plan was developed.

Hearings and Appeals: The FY 1983 budget for SSA's Office of Hearings and Appeals includes resources (1) to conduct more hearings by administrative law judges (ALJ's) when claimants appeal and (2) to improve the quality and consistency of the hearings decisional process. Budget assumptions include (1) increasing the corps of ALJ's from the present level of 728 to about 800 and (2) increasing ALJ productivity to reduce the backlog through increases in and better utilization of support staff, increased training and greater use of word processing equipment. Pre-effectuation review of a percentage of ALJ allowances, as required by the 1980 Disability Amendments, is aimed at improving the quality and consistency of ALJ decisions.

Workloads

SSA has a workload-based administrative budget, whose size is determined to a great extent by workloads generated by provisions of the law and demo-graphic factors. Some examples of principal workloads for FY 1983 are to:

--process over 3.2 million claims from retired workers, dependents and survivors; and more than 1.3 million SSI claims.
--keep the beneficiary rolls current for over 36.3 million persons under the Social Security cash benefit programs and for over 4.1 million SSI recipients.
--complete more than 3.4 million redeterminations for SSI eligibility and payment amount.

- --process more than 480,000 hearings and appeals from claimants who are appealing decisions concerning their eligibility and benefits, primarily in the disability and SSI programs.
- --post 204 million annual wage report items.

Employment and Overtime

In developing its administrative budget, SSA first arrives at the work-years necessary to process the estimated work that will come to the Agency. Work-year requirements are met from three sources: (1) full-time permanent employment, (2) part-time and temporary employment and (3) overtime.

The main thrust of the SSA employment request is to:

- --maintain a stable permanent work force to handle ongoing work. In 1982 and 1983 the full-time permanent employment remains level, with an estimated 74,129 positions filled at the end of 1982 and 74,142 at the end of 1983.
- --provide sufficient temporary employment and overtime to process one-time work. Our request for 1983 provides for 8,029 part-time and temporary work-years--a decrease of about 2,900 from the 1982 level. A large increase in temporary employment is provided in 1982 for processing certain one-time work. The budget for FY 1983 contains about 3,500 work-years of overtime, or about 4 percent of total Agency work-years.
- --eliminate non-essential work and hold down actual employment increases.

Disability State Agencies

In 1981 the disability State agencies spent more than $434,000,000 or 16.1 percent of our administrative budget. The 1983 budget request includes $669,000,000 for the State agencies, or 20.3 percent of our administrative budget. The major reasons that the Disability State agencies require an increasing share of our administrative budget include:

- --continued emphasis on payment accuracy and overall quality, consistency and validity of disability determinations.
- --the Disability Amendments of 1980. In 1982 this legislation is expected to increase State agency administrative costs by more than $103,000,000. In 1983 State agency administrative costs will increase by another $83,000,000 as a result of this legislation. The legislation provides for a Federal review of State agency determinations in Social Security disability cases before the award is more and the periodic review of current disability beneficiaries.
- --increased consultative examination purchases. The consultative examination rate--the number of consultative examination purchased as a percent of total number of claims processed by the State agencies--is to increase from 36.9 percent in 1981 to 39.8 percent in 1983.

Mr. Chairman, members of the subcommittee, I appreciate the opportunity to discuss the refugee and entrant assistance programs of the Department of Health and Human Services, and the budget that we are proposing for them for FY 1983.

Although refugee resettlement is a tradition in this country, permanent federal programs for this purpose are relatively new. The Refugee Act of 1980, signed into law in March, 1980, provides for the annual admission of refugees to this country and established the Refugee Assistance Program to enable and encourage these refugees to become self-sufficient as soon as possible. The Refugee Education Assistance Act of 1980, was passed at the end of FY 1980 in response to the emergencies associated with the unexpected arrival of over 170,000 Cuban and Haitian entrants in 1980 and 1981. This Act established the Cuban/Haitian Entrant Program through which assistance is provided to the entrants, who have been permitted to stay in the U.S. Entrants receive assistance on the same basis as refugees, again for the purpose of enabling these individuals to become self-sufficient members of our society.

The FY 1983 budget request for refugee and entrant resettlement is $532,152,000. This request is based on Congressional reauthorization of the Refugee Act of 1980, which expires at the end of FY 1982. The Administration will propose reauthorization with only minor amendments. This budget request is for a single appropriation for the Refugee Assistance and Cuban/Haitian Entrant Programs. We believe that a single appropriation is appropriate and necessary because of the similarity of the two programs and because of the need for flexibility in using program funds to assure the most effective resettlement of both populations. Such flexibility is critical due to the uncertainties in the arrival rate of refugees and entrants and in the assistance needs of the new and existing population.

There are seven activities in the refugee and entrant programs: State Administered Programs, Voluntary Agency Programs, Education Assistance for Children, Preventive Health, Cuban/Haitian Entrant Program, Targeted Assistance, and Federal Administration. I will discuss each briefly.

a) State Administered Programs

These programs include cash and medical assistance, social services and State administrative costs for the Refugee Assistance Program. We are requesting $471,849,000 for these programs: $412,562,000 for cash and medical assistance and related State administrative costs (CMA), and $59,287,000 for social services.

The level of funding needed for CMA is dependent on the number of refugees who are admitted to the United States and who have been here less than 36 months, the percentage of refugees who will require public assistance, and the reimbursement policy established by the Federal Government.

We also estimate that 131,000 refugees will be admitted in FY 1982 who would come under the State-administered programs and 103,500 in FY 1983. We also estimate that the dependency rate of the refugees who have been admitted since FY 1980 and who have been in the country less than 36 months will be 67%. We are implementing steps to reduce that figure.

The funding requested for CMA is based on the proposed FY 1982 regulations which would modify the assistance for needy refugees who are not categorically eligible for Aid to Families with Dependent Children benefits or Supplemental Security Income. The proposed regulations permit non-categorically eligible but needy refugees to receive AFDC level cash and medical assistance for their first 18 months in the United States, and receive benefits under their State or local General Assistance (GA) program during the second 18 months in the U.S. At present they currently receive full AFDC level benefits for 36 months. The basic purpose of these changes was to provide for more comparable treatment of refugee and non-refugee needy in the U.S., while still attempting to account for the unique circumstances of the refugee. Under this policy we reimburse GA costs, including administrative costs, incurred by the states in serving this element of the refugee population. The regulation would not affect the funding for those refugees, who are eligible for and receive AFDC, Medicaid and SSI for their first 36 months in the U.S.

For a variety of reasons, including the desire to give States sufficient lead time for implementation, this new policy did not go into effect on March 1, 1982. In order to afford the delay without making further modifications in refugee and entrant eligibility rules, it will be necessary to reprogram funds from other activities. We will have these reprogramming requests to you shortly.

Finally, the FY 1983 budget request for CMA includes the request for funds for unaccompanied refugee minors.

The funding needed for social services is used to provide a program of English language training, vocational training, and other support services to provide refugees with the tools to become self-sufficient. In FY 1983, we will target these funds more specifically to activities which foster self-sufficiency for refugees who are receiving cash assistance. We believe that this strategy offers the best chance for refugees to avoid long-term welfare dependency and achieve economic independence.

b) Voluntary Agency Programs

This activity provides matching funds on a dollar-for-dollar basis, up to a specified maximum of $1,000 per refugee to voluntary agencies for services in resettling refugees. The principal objective is to enable the refugees to become self-supporting and independent members of American society. Most of these funds are provided for the resettlement of Soviet refugees. A wide range of activities is covered including training, recertification in the United States for professionals trained abroad, social services, maintenance assistance, and health care. Funding is provided for this activity in lieu of regular State administered cash, medical and social service assistance.

We are requesting $11 million for this program in FY 1983, as we estimate that 11,000 refugees will enter the US in FY 1983 and participate in this program.

c) Education Assistance for Children

No additional funds are being requested for FY 1983. This program for education assistance for children was initiated in FY 1980 to relieve local school districts of the initial cost of meeting the special needs of refugee children. With the reduced refugee flows, we believe that the funds which have been appropriated since 1980 have built the capacity necessary to meet the current special needs of refugee children, and no additional funds are being requested in the FY 1983 budget for this activity.

d) Preventive Health

This activity, for which we are requesting $6,049,000 in FY 1983, funds two basic functions related to health care for refugees. The first is to monitor the adequacy of medical screening conducted overseas and to assure appropriate follow-up and treatment of refugees with diseases which might be a threat to public health. This work will be conducted by Centers for Disease Control (CDC) personnel stationed overseas and at ports of entry. They will work to assure the continued quality of medical screening and disease surveillance overseas and the inspection and notification procedures at ports of entry. The second function covers a modest grant program administered by CDC to support State and local health agencies which conduct health assessments and immediate follow-up care for a variety of conditions including skin infections, intestinal parasites, malnutrition, and anemia.

e) Cuban/Haitian Entrant Program

Under Section 501(a) of the Refugee Education Assistance Act of 1980, (the Act), Cuban and Haitian entrants are eligible for domestic assistance and services equivalent to that provided to refugees under the Refugee Act of 1980. We are requesting $17,343,000 for this program in FY 1983 to provide cash and medical assistance, social services, and related State administrative costs to support those entrants who still retain program eligibility in FY 1983. This request also includes funds to care for unaccompanied entrant minors. No further entrants are expected to arrive in FY 1983.

In previous years, we had requested funds under section 501(c) of the Act for the reception and care of entrants in processing sites and camps where they undergo medical and security screening and await resettlement or placement in American communities. In FY 1983, the Department of Justice will have this responsibility.

f) Targeted Assistance

We are requesting $20 million in FY 1983 to fund a program of flexible, targeted assistance for areas with high concentrations of refugees or entrants. Under this program States may apply for project grants to assist refugee/entrant populations in areas where supplementation of currently available resources is necessary due to the high concentration of refugees and entrants.

This program was initiated in FY 1982 to assist areas with high concentrations of Cuban/Haitian entrants. In FY 1983, States with high concentrations of refugees will also be allowed to participate in the program.

g) Federal Administration

The Refugee Act of 1980 established the Office of Refugee Resettlement in the Deparment of Health and Human services. This Office has the responsibility for the management of the Federal Refugee and Cuban/Haitian Entrant Programs. Through a Central Office, ten Regional Offices and one field office in Miami, Federal staff provide program direction, financial grants management and technical assistance to States, voluntary resettlement agencies and employment programs.

We are requesting $5,911,000 for this activity in FY 1983. This budget request is based upon a staff reduction of 22 positions. This reduction will be partially achieved through a realignment and tightening of Central and Regional Office responsibilities and functions.

I wish to thank you for the opportunity to address this subcommittee. I am prepared to respond to questions at this time.

FY 1982 Program Supplemental

Our requests before you today include a supplemental appropriation request of $42.9 million for FY 1982.

The third Continuing Resolution for FY 1982, made available to SSA $3,017,000,000 for the Limitation on Administrative Expenses account. Our plan for living within the $3,017,000,000 limitation assumed congressional authorization of changes in the Social Security Act or changes in the appropriation language to relieve SSA of certain administrative requirements to enable SSA to save $42.9 million.

We've done our best to live with the $3,017,000,000 by taking actions such as implementing additional procedural changes to save work-years, reducing work-years budgeted for staff support functions and reducing the equipment budget. However, to achieve further reductions cutbacks will be required in the later part of FY 1982 in undesirable areas such as work on benefit savings initiatives--for example, debt collection and continuing disability investigations, earnings enforcement, and certain automatic data processing expenses.

In order to continue the required work of the Agency, we've had to plan to use the $70 million contingency reserve which was part of the $3,017,000,000 made available to use under the third Continuing Resolution. Therefore, no further contingency is available.

We request your assistance in seeking congressional approval for the FY 1982 supplemental request. Of the total $42.9 million request, $6.8 million is for SSI administrative activities. We may have to propose adjustments later in the SSI appropriation--Payments to the Trust Funds for Administrative Costs activity--as a result of this supplemental.

BIOGRAPHICAL SKETCH

Name: JOHN A. SVAHN

Position: Commissioner of the Social Security Administration, and Director of the Office of Child Support Enforcement, Department of Health and Human Services since March 3, 1981.

Former Positions: Private Consultant on management problems and public policy since 1979. Manager, Government Services for Deloitte Haskins and Sells, Certified Public Accountants and Management Consultants, 1976-1979.

Administrator, U.S. Social and Rehabilitation Service, and Director, U.S. Office of Child Support Enforcement, 1975-1976.

Deputy Administrator, U.S. Social and Rehabilitation Service, 1974-1975.

Commissioner, Assistance Payments Administration, 1973-1974.

Acting Commissioner, Community Services Administration, 1973-1974.

Consultant to the Executive Office of the President, Office of Management and Budget, 1972-1973.

Director, Department of Social Welfare, State of California, 1971-1973.

Military Service, U.S. Air Force, 1966-1968.

Education: University of Washington, B.S. - Polictical Science, 1966.
University of the Pacific, McGeorge School of Law, 1969-1973.
Georgetown University, School of Law, 1973-1974

Awards: H.E.W. Secretary's Special Citation.
Commendation from the National Welfare Fraud Association.
H.E.W. - Administrator's Award of Achievement.
Wests Publishing Award--Most Outstanding Contribution to Legal Scholarship.

Personal Data: Born in New London, Connecticut, on May 13, 1943.
Married, two children.

SYSTEMS PLAN

Senator CHILES. All right, I want to ask you some specific questions on the refugee issue. And certainly your announcement is good news. But first, I think I should cover some of the social security areas.

The Department's 5-year plan to upgrade the Social Security Administration computer system is estimated at $478 million. How will that plan affect your 1983 budget request for the limitation on administrative expenses? Does that require any kind of authorizing legislation? And how much of that $478 million is needed for fiscal year 1983?

In other words, how much is in your present budget? And are we going to see a supplemental for the remainder of that?

Mr. SVAHN. Well, supplementals are not too popular, as you can imagine, Mr. Chairman. We do not anticipate the need for any authorizing legislation in order to be able to upgrade Social Security's data processing capability.

Let me just comment for a moment on the sad state of affairs that exists in Social Security's data processing system. That system was a model system back in the early and mid-1960's and has basically remained frozen since that time. We have some very, very serious problems, and in fact we have right now a backlog of about 120,000 hours of processing time.

That means that for the 36 million beneficiaries who receive social security checks and for the 115 million people who pay social security taxes that we are unable to provide the services that we are required to provide by law.

It is, as I said, a sad state that we have allowed this to transpire over the years, and it is my No. 1 administrative priority to solve Social Security data processing problems.

As you pointed out, we just recently released a new 5-year strategic plan. It is a plan that differs from all plans that Social Security has put together in the past in that it addresses the four major areas of data processing problems. It deals with software, it deals with our hardware, it deals with our data base, and the fact that we are a tape-oriented sequential system. And it deals with our inability to communicate with the field and to answer questions from beneficiaries all around the country.

In terms of the cost, we have estimated $478 million over a 5-year period. We believe that we will be able to handle the fiscal year 1982 amount out of our current budget, and we are short in fiscal year 1983 by about $22 million.

Now, again, I emphasize that right now that is very much an estimate. And we have not proposed any budget amendment for fiscal year 1983 nor have we requested any more money for the plan in the present budget request. We will absorb the 1982 cost.

Out of, I believe, the total amount we were talking about spending in fiscal year 1983 about $136 million for incremental systems modernization costs. I would have to check that figure.

I am sorry; $133 million. And we think we are about $22 million short on that.

But again, as I say, it is an estimate.

DEBT COLLECTION

Senator CHILES. The committee understands that the Social Security Administration is undertaking a massive debt collection initiative. Mostly, this consists of reclaiming overpayments to beneficiaries. It should be noted that many beneficiaries were overpaid, and they received these payments as a result of Federal error and not fraud if my information is correct.

Mr. SVAHN. Oh, that's absolutely correct, Mr. Chairman.

Senator CHILES. Well, how does the Social Security Administration set out to collect these overdue debts? And what is your best estimate of the amount that is owed to the Social Security Administration?

Mr. SVAHN. Well, Mr. Chairman, when I came into the Social Security Administration about 10 months ago, I requested a statement of debts owed to the Social Security Administration. At that time, our—for lack of a better term, I call it—accounts receivable were about $1.9 billion. Most of that comes from overpayments made to beneficiaries, and that is the amount that was currently carried on the books as owed to Social Security. The actual amount is considerably higher than that.

We have begun a debt management program to collect those overpayments. As you point out, much of that amount is due to the Government's error, and much of it is attributable to the failure of Social Security's data processing system to react to changes that occur in beneficiary circumstances.

We are in the process of mounting a fairly substantial effort to recover those overpayments. I have to say that most people are quite reasonable about paying back the amounts that are owed to the Government. Our collections for the first quarter of this fiscal year are running about 25 percent higher than they have in past years.

So we are just beginning this debt management program, but it is beginning to show results. Perhaps somebody can pass up the numbers as to what we anticipate we will collect, but I think it is about $1.5 billion for fiscal year 1982.

Now, at the same time, we recognize that that doesn't mean that the amount of outstanding debt owed to Social Security will then be $400 million, because we are creating new debt everyday. But we are working to cut down that flow.

Senator CHILES. And until you get your processes modernized and brought up to date, you are going to continue to have these errors?

Mr. SVAHN. That's correct, Mr. Chairman. I am working to prevent the overpayments. I think that it is much better to run an efficient operation and pay accurately and prevent overpayments than it is to go ahead and make the overpayments and then spend the money to try and collect them back.

Senator CHILES. What steps are you taking to insure that repayment does not burden a needy recipient, someone who, yes, he got the money, but it wasn't his fault or wasn't her fault? They have spent the money, and their circumstances are so dire that if you withhold payments from them, you are going to invoke great hardship.

Mr. SVAHN. Well, we will not be invoking great hardship, Mr. Chairman. Our debt collection procedures are, well, I won't say voluntary, but they are much easier perhaps than in private debt collection. We do look at a person's circumstances. We do set up repayment schedules. We do provide due process if they owe the money back to us.

We are more after the chronic debtors than we are after someone who has received a small overpayment through no fault of his own and cannot afford to pay it back. We do waive outstanding debt in circumstances where a person is without fault in causing the overpayment and would be placed under a hardship to repay it. But we do have a phenomenon, whereby people incur routine overpayments. Some people go into an office and estimate that their earnings for the current year will be below the limit, which is $6,000 right now for beneficiaries aged 65 and over, and then continue to work and get a full social security payment until the end of the year. Then they owe Social Security back all of those payments.

We are trying, as I said before, to work to prevent that and not create a hardship.

FISCAL YEAR 1982 SUPPLEMENTAL REQUEST

Senator CHILES. Your budget justification states that the $42.9 million supplemental you are requesting is needed because Congress failed to make "legislative changes" not contained in the continuing resolution. Were these proposed legislative changes officially submitted to Congress? And if so when?

Mr. SVAHN. Well, I understand that there have been a number of discussions about whether or not those changes were officially submitted to Congress. I know that substantive legislation was not put forward, but during the continuing resolution process, I believe Senator Schmitt received a letter from the Department indicating that there was certain language that the Department would like placed in the continuing resolution which would have effected a $42.9 million saving.

I might defer to Mr. Itteilag on that, and he could go into a little more of the detail as to what notification was given to Congress and what requests were made.

Senator CHILES. Yes, sir.

Mr. ITTEILAG. Senator, on December 9, the Secretary corresponded with Senator Schmitt and Senator Hatfield and with the House to indicate that as part of the final negotiations over the continuing resolution, we needed certain point of order language in the continuing resolution in order to meet the amount of money that the Congress and the OMB had agreed to provide for the limitation on administrative expenses account.

So in that sense, we did inform this committee and in fact the House Appropriations Committee. But it is not something that one would characterize as an official budget submission.

Senator CHILES. No; I don't think one would characterize it that way, not being signed by the President, not being submitted formally. In fact, if my memory is correct, it would be that the September budget request was $2.946 billion, and a serious effort was made by the administration to have Congress enact that level. At least, that was OMB's position, and their official position.

Congress, in effect, pulled your chestnuts out of the fire and gave you $3.017 billion. And now to see it characterized that you have got a shortfall because Congress failed to enact some legislative changes doesn't seem to me to be the best way to characterize this past scenario.

Mr. SVAHN. I would agree with you about the characterization, Mr. Chairman, and as I said over the past few days I was looking into it and trying to find some official notification. I regret the blame apparently being laid on the Congress.

If I could just for a moment, Mr. Chairman, talk a little bit about that $42.9 million supplemental. I recognize we currently have $3.017 billion as part of the continuing resolution, but if we are not successful in getting the $42.9 million supplemental because of where we are in the fiscal year, we are going to have to not do some things that I felt were extremely important for social security to do this year.

One of them has not been done since 1978 earnings were posted. That is the annual recomputation of benefits for social security beneficiaries. Social security beneficiaries are entitled to an annual recomputation of their benefit based on continued earnings after they begin to collect social security.

What that means is that a great number of beneficiaries have been receiving underpayments since their benefits have not been adjusted automatically for any earnings after calendar year 1978. This is one of those things that I had planned on being able to do this year, at least for earnings from 1979 and 1980. We will not be able to do that if we do not get the supplemental.

The debt collection effort also turns on the $42.9 million supplemental. I guess I would have to say that anything that is new that we were going to try to do, since we are so far along in the fiscal year, we will have to postpone doing. And I think there are some things that we are planning on doing which are very worthwhile, and we should accomplish them.

WORK INCENTIVES IN AFDC

Senator CHILES. Going now to aid to families with dependent children, your budget proposes to cut another $1.1 billion from that program. A major study by the University of Chicago has concluded that your program as enacted last year contains tremendous disincentives to work by cutting benefit levels to people who take jobs.

The Congressional Budget Office estimates that in minimum benefit-level state, a family of four with $400 a month earnings and child care expenses would lose 45 percent of its benefits after 4 months of employment. Under the old law, if they didn't work, they would get $529 a month. If they earned $400 a month, their net income would be $648. So they had a real gain of 23 percent from working.

Now, they would actually go down from $495 to $490 a month. So there is no net gain for working.

I realize we have a difficult tradeoff between targeting incentives to people whose work will only bring in the minimum wage and to target our funds to the lowest income groups. But when I see calculations that you can do better on welfare than by working, I question whether we have unbalanced the system.

Mr. SVAHN. Well, if I can just make a comment or two, Mr. Chairman, then I would like for Mrs. McMahon to answer that.

Senator CHILES. Yes.

Mr. SVAHN. I have not seen that study yet. We had some problem trying to get a copy of it. But I have read other studies done by the same people over a period of about 10 years during which time I have been involved in management of welfare programs in one way or another. They generally tend to indicate that people would rather be on welfare than working, and I think that that is a sad commentary.

Our efforts in the AFDC program are geared to target the assistance to people who are most in need, and I don't think that people should have the option of working or being on welfare. I think that welfare should provide enough to a person who has no other place to turn so that they can live a dignified existence when they are in true need.

For persons who have the option of earning their own living, I think that they should exercise that option.

If I could ask Mrs. McMahon, she will talk a little more about that study because I understand she has read it.

Ms. MCMAHON. We are in the process right now of assessing the University of Chicago Center for the Study of Social Policy study, and we would like to provide a full answer for the record once we have done that.

I would like to make a couple of comments, however.

Senator CHILES. I would like you to address the CBO study as well.

Ms. MCMAHON. They are related, and we will do that in the record. But they are basically the same issue, showing how much you get if you are working or not working, getting welfare or not getting welfare.

[The information follows:]

SSA ASSESSMENT OF UNIVERSITY OF CHICAGO STUDY

The University of Chicago's Center for the Study of Social Policy recently analyzed the purported impact of last year's AFDC legislation and the potential effects of the Administration's 1983 budget proposals on low income families. The study claims work incentives for low income families will be eliminated, that low income families will become more, not less, dependent on welfare and that projected savings will not materialize. The study is defective in three major ways:

1) it contains some inaccuracies;

2) the figures cited do not support the conclusions; and

3) it makes unexamined philosophical assumptions which cannot be supported.

Although the study deals with both last year's changes and the proposed 1983 changes, with respect to AFDC it deals with the latter only briefly, and, where it does so, erroneously. For example, it claims that energy assistance will be counted dollar-for-dollar against AFDC benefits, whereas the Administration's AFDC proposal is to count energy assistance only to the extent that it duplicates the amounts for heating and cooling that are in the AFDC payment standard. The study also claims that the Administration proposes to remove children from the grant when they reach the age of 16, whereas the Administration proposes to remove only the needs of the caretaker when the youngest child reaches 16. With respect to AFDC, the findings by-and-large go over the same ground as the study the University of Chicago did last year with the main focus again being on the elimination of the $30-and-one-third after four months and the standardization of the work expense disregard.

The main difficulty with the study is that, despite the fact that it presents masses of numbers, the study presents no direct, empirical evidence for the claim that the AFDC provisions have decreased, or will decrease, the work effort of AFDC recipients. Furthermore, analysis of the data that the study uses to arrive at this conclusion shows that, because it uses data from out of their original context, the very relevance of the data to the conclusions is doubtful.

One clear example of this is the claim that some families will actually be worse off financially if they work than if they don't. With respect to AFDC, the main factor giving rise to this "finding" is the study's use of average work expenses from the 1979 AFDC Recipient Characteristics Study. Since that study was conducted prior to the 1981 changes when there were unlimited work expenses that could be deducted from a recipient's countable income, there was no incentive for recipients to economize in their work expenses. In fact there was a positive incentive for recipients to maximize their expenses to stay on the rolls at higher income levels. In most cases, the only mandatory work expenses for low income families are FICA and State and local income taxes, since their Federal income taxes are low to non-existent. Other expenses such as transportation and clothing are within the control of the individual, and considerable economies can be realized by recipients. Last year's AFDC changes provide the incentive for recipients to do this, and thus, the study's use of earlier data on work expenses does not give a true picture.

A second weakness of the study is that it implicitly assumes throughout, and sometimes even directly asserts, that the previous system of disregards was effective in moving families into independence. Thus the study asserts that last year's provisions "eliminate the incentives to work for families that are trying to earn their way off the rolls" (p.1). This completely ignores the abundant evidence that the previously permanent $30-and-one-third disregard, which is the main factor in the changes engendered in the study's "benefit reduction rates" by the AFDC changes, had just the opposite effect -- it served to maintain AFDC families on the rolls indefinitely, without increasing the percentage of AFDC families that worked. Thus both before and after the introduction of the $30-and-one-third, and indeed throughout the 60's and 70's, about 14% of AFDC mothers had earnings. Furthermore, in 1967, before the $30-and-one-third was enacted, about one-third of the households who left the rolls did so because of increased earnings, but by 1979 less than 10% did so. Clearly the reason for this was that the disregard allowed recipients, even with relatively high incomes, to continue to receive AFDC and thus preserved their dependence on the system. This allowed AFDC to become an income supplement program for individuals able to work, rather than a social safety net for those with no other source of income. Thus rather than providing an effective incentive for welfare recipients to "earn their way off the rolls" by making work more attractive than welfare, the permanent $30-and-one-third only served to make the combination of work and welfare more attractive to some individuals than just work alone.

The problem of making work more attractive than welfare suggests a third difficulty with the University of Chicago analysis; except for one page, buried well into the report (p. 23), it ignores the possibility of using work requirements to make welfare less attractive. The only form of work incentive that the study takes seriously is a positive answer to the financial question whether at a particular moment an individual contemplating work will have more, and how much more, money by working than by not working. In so doing, it ignores the insoluble problems of posing the work/welfare issue simply in financial terms. If one rejects work requirements, the only arrangement that will provide a low benefit reduction rate for welfare families is either a system that pays extremely low benefits to those who are unable or unwilling to work and thus penalizes those in the first category, or a system that allows individuals with such high incomes to continue to receive welfare that a substantial segment of the population would permanently depend on other taxpayers. The only way out of this dilemma is to take work requirements seriously. No system of welfare will work, nor will it be accepted by the American people, which allows an able-bodied individual to calculate and choose: "Will I be better off if I work or if I allow myself and my family to become dependent upon the work of other individuals?" By enforcing current work requirements and by strengthening them, potential able-bodied recipients would not be given the choice of "decid[ing] to become totally dependent on welfare" (p.21).

The study briefly suggests that work requirements of this sort are not workable. It suggests that it will be difficult to document if a person quits or loses his job. Actually this decision is routinely made with respect to Unemployment Compensation. Furthermore, able-bodied applicants and recipients can be required to look for work and to participate in community work experience. The study suggests that the latter has been tried and has failed, because the work that would be provided does not usually develop skills that would help the recipient to find other employment. Three points need to be made here. First, any job provides skills, such as good work habits and a work history, which are relevant to finding other jobs. Second, States are already identifying jobs such as school or hospital aides, which clearly provide valuable experience in finding other jobs. Third, with respect to the work incentive issue, the point is not simply that the community work experience jobs should lead directly to private sector jobs, but that the choice of an individual not to work, and instead be supported by the labor of others, should not be an available option. Thus, the study ignores the posibility of reforming welfare by systematic strengthening of work requirements and instead suggests the return to a system which has proven itself to be hopelessly defective.

SSA ASSESSMENT OF CBO STUDY

The Congressional Budget Office (CBO) staff memorandum, "Cumulative Effects for Selected Households of Benefit Reductions Enacted in the AFDC, Food Stamp and Housing Subsidy Programs" is based on an analysis similar to that of the University of Chicago Study. Although it is, by-and-large, more guarded in its conclusions, it also argues that some families will be financially worse-off working and that work incentives *may* thereby be decreased. The CBO staff paper has some problems similar to those of the University of Chicago study. For example, where it discusses work expenses, it uses averages from 1979, thereby ignoring the incentive towards economizing work expenses that are implicit in the new legislation. Additionally, although the study only suggests that work incentives *might* be diminished, it fails to note that they *might* be increased because of the strengthened work requirements. Like the University of Chicago study, it examines only the immediate financial aspects of the work incentive issue, and does not address the problems inherent in the permanent $30-and-one-third approach and the possibilities of more effective incentives embodied in stronger work requirements.

The main focus of the CBO study is on the benefit reductions that some families will incur as a result of the changes. The study, for example, finds that families with earnings "lose a much larger proportion of their total benefits than households without earnings" (p. i). This is neither surprising nor undesirable, given that many of the AFDC changes had the aim of reducing benefits to such families in order to target resources on families without other sources of income. A problem with the way in which CBO's findings are presented is that, because the study never asks the threshold question of whether families should have had these benefits in the first place, it may mistakenly suggest that such families are incurring an unfair burden.

A similar point can be made with respect to CBO's claim that non-earners will incur losses if States enact the option to count food stamps and low income housing subsidies as income against AFDC benefits. The study simply does not examine the extent to which real duplication of assistance exists in Federal programs.

Finally, CBO does not address what consequences may have occurred in terms of across-the-board cuts to all recipients if targeted reductions had not been imposed. In some States fiscal problems have already resulted in delayed benefit increases and/or actual benefit reductions which harm all recipients. Savings from the 1981 AFDC changes will relieve these States from the need to make further cuts and in some cases will enable them to increase payment levels to their neediest recipients.

ELIMINATION OF $30 AND ONE-THIRD INCOME DISREGARDS

Ms. McMahon. I would like to make a couple of points. One is that because both of these studies turn very heavily on the fact that we are, after a 4-month period, eliminating the $30 and one-third income disregard which has been called a work incentive. In fact, it has not been a work incentive both before and after the inception of the $30 and one-third provision, about 14 percent of those on welfare were working.

The number has not gone up. That has been basically a constant number over time. So in fact, what has happened is not that the $30 and one-third was an incentive for more people to go to work and to leave the welfare rolls, but that more people have been able to remain on welfare indefinitely while they are working full time at a minimum wage and in some states working full time getting as much as $15,000 or $18,000 a year. We do not feel that that is what Congress intended when the $30 and one-third was passed.

We think that a transition period of 4 months, which we are granting, is exactly what Congress had in mind. It does provide people some additional money for a transition period. We think that is fine, and we are supporting that.

Another point I would like to make is that prior to the $30 and one-third being put in place, 33 percent of those who left welfare left due to earnings.

What was expected by Congress with the $30 and one-third is that more than 33 percent would be leaving the welfare roles because of earnings. They would get a job, and then they go off welfare. However, that number is now down to less than 10 percent. So we have a precipitous drop in the number who are leaving welfare due to earnings rather than an increase.

In addition, that disregard has created serious inequities between non-AFDC working families and AFDC working families. So we would like to correct this inequity by which people who have been on welfare, get a job, and are allowed to stay on welfare. Now we are cutting them off the rolls.

The inequity is where people never went on welfare, and they are working at the minimum wage. They have less disposable income than people who are on welfare.

Another thing, I think a point that the Commissioner made that I would like to follow up on is that in fact, we are told by the same people who do these studies, which indicate that people would rather be on welfare than work, that all those people really want to work.

Well, we feel they do and that when people have jobs, they are going to continue in those jobs.

MANDATORY WORK PROGRAMS

Senator CHILES. Speaking of that, will you provide the States with any funds to run these mandatory community work experience programs? I know you are planning further cutbacks in training programs under the Labor Department. Will the regular AFDC rate be available to obtain replacement of administrative costs for mandatory work programs?

And how much do you expect them to cost? And how many people will they put to work?

Ms. MCMAHON. The regular AFDC administrative money is available for community work experience programs, for job search, for similar work activities.

In addition to that, we expect because of both the 1982 changes in the program which are creating a drop in the caseload, and proposed changes in the 1983 budget which would create an additional number of case closings; 150,000 applicants would be diverted from welfare due to mandatory job search that we are proposing in 1983, and if you block together, as we are recommending, the administrative costs of several programs, you are going to eliminate a number of bookkeeping requirements.

All those things are going to create a cushion in the administrative cost to the States that will allow them to free up money to do community work experience programs and other related community work programs.

Senator CHILES. I am delighted to welcome this morning the chairman of the subcommittee, Senator Schmitt.

Senator SCHMITT. No, please proceed.

Senator CHILES. If you have any questions——

Senator SCHMITT. I apologize for not being here for the entire morning, but I am sure the Senator from Florida has done an outstanding job. And I appreciate it.

SAVINGS FROM WORKFARE

Senator CHILES. Last year, Congress rejected an administration proposal to require so-called workfare programs for all AFDC recipients. Congress voted instead to permit States to set up workfare programs.

This year, the administration is requesting a compulsory workfare program. The States' enactment of this requirement would save $49 million.

Based on what data and assumptions does the administration assume such large savings from this proposal?

Ms. MCMAHON. There are several workfare demonstrations that have been going on in the past few years. One is the food stamp workfare project. Under that project, there was actually, I think, a 28-percent deterrence factor. Because we wanted to be conservative in our estimate, we are looking at a 14-percent deterrence through CWEP.

We also have mandatory job search in our budget, and we are assuming that a number of people will be diverted from the rolls and that also because of other proposals, the rolls will go down. Therefore, the number of people that States will have to deal with through CWEP will be somewhat smaller than what it is now.

In addition to that, people will actually be getting job experience. We have found that in a number of similar projects, people actually do get jobs in the private sector based on the fact that they now have work experience which they did not have before.

Employers are willing to hire them where they would not have been willing to before. Utah is a good example of that. Their work experiment program, during one 4-month period, was reported that 18 percent of those who were assigned to their projects were removed from the grant for failure to perform, and another 27 percent actually obtained salaried employment.

We have additional examples of that nature, and we are basing our savings on those figures.

MICHEL AMENDMENT

Senator CHILES. States are currently required under the amendment to reduce their error rates to 4 percent by the end of fiscal 1982. The Reagan administration is now proposing that States be required to reach a 0-percent error rate by 1986.

How many States and which States might be affected by your regulations that require the AFDC error rate to be reduced in annual stages to a maximum of 4 percent by 1983?

Mr. SVAHN. I think that every State is affected by that, Mr. Chairman.

Senator CHILES. And all currently exceed the 4-percent error rate.

Mr. SVAHN. No, sir; there are a few States right now—I believe Iowa, Nevada—there are several that are below the 4-percent level already.

Ms. McMAHON. I have that. I will give it to you in 1 second.

Senator CHILES. I will take that for the record.

Ms. McMAHON. All right.

[The information follows:]

STATES WITH AFDC ERROR RATE BELOW 4 PERCENT

Based on the quality control findings for the April–September 1980 review period—which is the latest data available—49 of the 53 jurisdictions (excluding Guam) exceeded a 4-percent error rate. Iowa, Minnesota, and Nevada have error rates below 4 percent, and Oregon's error rate is right at 4 percent.

HIGH ERROR STATES

Senator CHILES. Tell me, what percent of the welfare population lives in the high-error States?

[The information follows:]

CONCENTRATION OF WELFARE POPULATION BASED ON STATE ERROR RATES

The welfare concentration in terms of State error rates is as follows: 3 States comprising 2.6 percent of the national welfare population have less than a 4-percent error rate; 20 States comprising 39.3 percent of the national welfare population have an error rate ranging from 4 to 6.9 percent; 20 States comprising 31.9 percent of the national welfare population have an error rate ranging from 7.0 to 9.9 percent; and 10 States comprising 6.2 percent of the national welfare population have an error rate of 10 percent or more.

REDUCING AFDC ERROR RATES

Mr. SVAHN. Well, Mr. Chairman, this issue of reduction of error rate in the AFDC program has been with us since December 1972 when the then HEW originally proposed to eliminate payments or eliminate Federal matching for erroneous payments. In other words, zero tolerance rate beginning in January 1973.

States have been working to reduce those error rates. There is kind of a myth that exists that says if you are in a big State, it is impossible to reduce your error rate.

Now, Los Angeles County in California is a fairly large jurisdiction and runs a welfare program with a very low percentage of erroneous payment. I think that Indiana has had a very low percentage of error, and it has managed that even given the fact that in Indiana, you have some very large urban areas.

I think that States are able to reduce their error rate, and I think that to reduce their error rate below 4 percent is not an impossible task.

Senator CHILES. What is the average error rate nationwide for the program now?

Ms. MCMAHON. Right now, it is 7.3 percent. That is as of the last reporting period, April to September 1980.

Senator CHILES. There has been some criticism that it might cost more to obtain a zero-error rate than the savings that would accrue from such an achievement. Kindly respond to that.

Mr. SVAHN. Well, I have heard that same criticism. And in fact, there are States who have said to us in the past or said to the Department or the Federal Government in the past, "It is cheaper for us to take the penalty rather than to reduce our error rate."

I think that the policy choice is there to the extent that the State has the authority and has the latitude to define its own eligibility criteria and to make its own eligibility determinations. Then they have the capacity to control their error rate, and the Federal Government should not be participating in the State's lax administration of its program.

Now, on the other hand, Mr. Chairman, having been a State welfare administrator myself, I know that it gets very difficult to get that error rate down. I do think that I have fought, in the past, the Federal Government and have objected strenuously to proposals to reduce the error rate to zero.

I am not even sure that we can sample well enough to say what the error rate is when it gets down to that finite a number.

So I have been on both sides of the issue. But I think that the Federal Government has an obligation not to participate in those erroneous payments.

Do you have anything to add?

Ms. MCMAHON. I think one thing I could add is if you just look at the States that had the highest error rates and would have been sanctionable under this last period, if we had decided to take sanctions—in fact, we are working on corrective action plans—you have a mix. You have New York, and you have Arizona. You have Rhode Island which is a small northern State, and then you have Colorado. There is a mix.

I don't think we know the reasons for these variations. We have looked at the administrative costs that a State spends, cost per case, error rate, and there really is no direct correlation between those things. A lot of it has to do with just what kind of management commitments you get in a State.

By putting additional pressure on States to get their error rates down, we think we will get more of a management commitment, and they will come up with more efficient and effective ways to run their programs.

FISCAL YEAR 1982 BORROWING FROM FISCAL YEAR 1983 FUNDS

Senator CHILES. The committee notes that the Social Security Administration is planning to bring forward almost $929 million for the shortfall in the estimate of AFDC programs. That represents a 15-percent underestimate of the program cost. It appears that the Social Security Administration is making unrealistic estimates of the savings from legislative proposals and actually that hides the true cost of the AFDC program.

How do you explain that?

Mr. SVAHN. Well, let me just say, Mr. Chairman, we are not trying to hide the true cost of the AFDC program. I don't think that we could do that. We have estimated that due to a slower than desired implementation of Reconciliation Act provisions in AFDC, and given the status of the economy, we will have to borrow $728 million out of fiscal year 1983.

This includes the $201 million that we have estimated as 1982 savings as a result of early implementation of legislation that is proposed in the 1983 budget. This legislation would have to be effective and implemented July 1, 1982, in order to get that $201 million.

I think that is where the $929 million comes from. We are not trying to hide anything. It is very difficult to estimate such things as what goes on in the economy, and how fast States are going to be able to implement certain provisions of law once they are enacted and what the effective dates might be.

That is what has caused that shortfall. That is very close to the $1 billion cap that we have on our ability to borrow from one fiscal year to another.

SAVINGS FROM LEGISLATION

Senator CHILES. Congress in general is somewhat upset by the fact that the administration has assumed legislative savings resulting from enactment of controversial proposals. And that is not new with this administration. That happens time after time. But in the case of the child support enforcement program, the administration is assuming $145 million in savings based on proposals that haven't been submitted to the Congress yet.

How do you justify that? And are you prepared to inform Congress what these proposed initiatives are?

Mr. SVAHN. Yes; I hope we will, Mr. Chairman. No question about it. We will be submitting proposals to the Congress, legislative proposals, substantive proposals, to implement, basically, a restructuring of the financing of the child support enforcement program.

I have with me today Mr. Fred Schutzman who is the Deputy Director of the Office of Child Support Enforcement to answer any questions you might have about just what those proposals are.

Basically, as a result of the evaluation that has been going on, we have found out that the child support program under title IV(E) of the Social Security Act, which was signed by the President in January 1975, is a good program. It is a successful program over the past 7 years, although it has undergone startup pains and that kind of thing; but it has reached a point now where we, the Federal Government, are paying more and more for less and less return.

The administrative costs of the program are expanding rapidly to the point where some States are claiming more in administrative costs than they are collecting in child support.

What we are proposing to do—and we will be sending legislation up—is to restructure the financing of the program to encourage States to increase collections and to provide fiscal incentives for them to do that with reduced administrative costs. In other words, to make the collections as economically and efficiently as feasible.

Mr. ITTEILAG. Senator, if I could also comment on your general comments on the inclusion of proposed legislation in the appropriations estimates: This was not a policy that was limited to the Social Security Administration or, indeed, even the Department of Health and Human Services. It was a policy that the administration has used on a Governmentwide basis. And we are just one of the Departments that has been caught up in this.

I would also point out that even though this represents a change in the way the appropriations estimates are being made from previous years, it really has no effect on the bottom-line outlays in the budget as compared to past years.

COMBINED WELFARE ADMINISTRATION

Senator CHILES. The administration is proposing a new combined welfare administration block grant to provide States with funds to pay for the administration of medicaid, AFDC, and the food stamp program. This program would be capped in fiscal 1983 at 95 percent of the 1982 level, which would provide savings of $256 million.

At a time when the administration is proposing to insist on a zero-error rate in these programs by fiscal year 1986, how do you rationalize capping the administrative payments for AFDC and medicaid?

Mr. SVAHN. Well, I think one thing, when I was a State welfare administrator in the State of California, that never ceased to amaze me was how many people we had in the State of California who were working on cost allocation plans so that they could correctly allocate the administrative costs of the department to the various programs that were all run by the Federal Government.

I think that by combining the administrative cost accounts of these programs, we are going to eliminate a lot of the redtape that the States currently have to go through, and we will be providing them with a considerable amount of flexibility in the administration of their programs.

Also, we are not going to be requiring the States to spend $1 for every $1 of Federal money they spend. If the State can economize and efficiently operate its program, then it would be saving State dollars.

I am not just looking at it from the perspective of the State, but I think that there are several significant pluses to the proposal to combine those accounts and to provide them to the States without a requirement for a Federal match.

I also think that the reduction of 5 percent is more than offset by the elimination of Federal requirements and redtape that currently exist in the system as it is now.

ERROR RATES AND ADMINISTRATIVE COSTS

Senator CHILES. But it is going to be more of a burden on the States to try to go to a zero rate, is it not? And that is going to propose some cost on their part to try to do that.

Mr. SVAHN. Well, as Mrs. McMahon indicated, Mr. Chairman, there is no correlation between the amount of money a State spends in its administrative cost area and the error rate that the State has.

Senator CHILES. Did you think that was true when you were in the State?

Mr. SVAHN. Well, no. I have to say that sitting on the other side of the table, of course, you look at it from a different perspective. But it was true.

And I believed then that we had to spend more money in order to reduce our error rate. I am not so sure that that is the case, though, because my neighbor right next door at the time, the State of Nevada, had a very low administrative cost, and their error rate was extremely low.

It isn't necessarily the case that the more administrative dollars you throw into the pot the better you are going to be.

Senator CHILES. You don't think population had anything to do with it, the low population that Nevada had?

Mr. SVAHN. In the State of Nevada? Well, we had a county-administered system in the State of California. We have a very low population in a lot of the State of California, also, there was no correlation with low error.

Mr. ITTEILAG. Senator, I could also comment in this area.

The problem we face here is one of unconstrained growth over a period of years. And members of this subcommittee staff have expressed interest in this particular problem in the past. These types of costs, including those for medicaid, have grown by nearly 2½ times since fiscal 1974. And at a time when the Federal Government is trying very, very hard to limit its own administrative costs, we think it is only reasonable that we have some constraint at the State and local level in this area as well.

Mr. SVAHN. If I could add to that, Mr. Chairman, we mentioned earlier about the child support enforcement program, and I indicated that some States spend more in administrative costs than they collect. In fact, in the State of New York, their administrative costs are about half again as much as the amount that they bring in.

Other States are experiencing 7 or 8 to 1 return on their dollar of administrative costs. I just don't think there is any relationship. It has got to do with management.

A lot of the error we find in the AFDC program is built into State law and State regulations and State option. States are capable of changing that.

Senator SCHMITT. Mr. Chairman, will you yield for a moment?

Senator CHILES. Yes.

ERROR RATES AND AUTOMATION

Senator SCHMITT. Is it intended that the States, in order to reach a zero-error rate, fully automate their systems?

Mr. SVAHN. Senator, it is not intended that they do that. States, of course, do have the option, and we are providing the 90-percent funding for them to do that.

Traditionally, in State government, the AFDC program has been the—I don't know what you call it—stepchild of the State government. The medicaid program early on got medicaid management information systems and increased funding for that.

The child support enforcement program got increased funding for its operation. And the AFDC program, which is really the linchpin of all of the State welfare programs because of its basic eligibility criteria and the categorical relationship for medicaid and child support and that sort of thing, is the one that hasn't been automated.

Very few States have good data processing systems for their AFDC programs while their medicaid or child support system might be very good. We are encouraging States to move.

Senator SCHMITT. Does that contribute to the higher error rates? Is there any correlation between automation and low error rate?

Mr. SVAHN. I would have to ask Mrs. McMahon about that. I don't know of any correlation between the two.

Senator SCHMITT. Do you know of any correlations? I get the impression here that you are saying it is sort of random that there are no systematics here at all, and it is sort of hit or miss whether there is a low-error rate or not.

I don't believe that, but that is what you are telling us.

Mr. SVAHN. I think that the correlation, if you can make a correlation, deals with the State's management of its program.

Senator SCHMITT. Yes; that's easy to say, but what is it in the management that is different? Can't you provide us with some insight into this?

Ms. MCMAHON. I think you can look at certain things that go into these programs. Some of the things, the States have control over, some they don't.

Demographic characteristics have some impact on administrative cost, error rates, those kinds of things. The quality and adequacy of staff, how much of its resources the State wants to put in, but also the quality of those resources. Commitment of top management. It is the same issue in congressional offices, in executive branch offices; some people are just better managers than others.

There is really nothing that you or I could legislate or require.

Senator SCHMITT. So by imposing penalties if a certain error rate is not met, you are going to force the voters of a State to legislate competent State officials who in turn will appoint competent State officials; is that correct?

Ms. MCMAHON. Maybe that is a side effect.

Senator SCHMITT. Side effect—that better be the effect to cure the problem you just described.

Ms. MCMAHON. Let me point out between fiscal years 1979 and 1980, 11 States decreased both their administrative costs per case and their erroneous expenditures per case. So you had a decrease in administrative costs as well as error rates.

On the other hand, 12 States had an increase.

Senator SCHMITT. Does that suggest if you use fewer people, you get a lower error rate?

Ms. MCMAHON. Then, on the other hand, 12 States had an increase in their administrative cost and their error rate. Then, you had some States that decreased one and increased the other, and the reverse.

So the point is that no obvious correlation exists, some people just have an ability to do more with less and to——

ZERO-ERROR TOLERANCE

Senator SCHMITT. Without an obvious correlation, how can you justify shooting for a zero-error rate? See what I am getting at?

Ms. MCMAHON. Part of it is that we feel the Federal Government should not participate fully in erroneous payments.

Senator SCHMITT. I agree with that, but if you are going to institute a new program, a zero-error rate program, you have to have some hope of success. You cannot just stand there on principle which we all agree with, not to participate in a higher error rate system. But you still have to have some means of assuring that a low-error rate system is going to come into existence.

Ms. MCMAHON. If you look at the progress States have made since 1973 in AFDC, they have gone from 16-plus error rate down to 7.3. And we feel by having this kind of a proposal and continuing to work with States on—for instance, we have monthly reporting now in place that we requested last year that Congress passed. That is going to be an additional tool for States to use.

We are continuing to work with States on their automated systems. So we are providing technical assistance to States on a number of issues, continuing to work with them to help them get their error rates down. We think that in combination with the zero-error rate, in terms of what we will do for Federal financial participation, this is the right way to go.

DATA OPERATIONS CENTER

Senator SCHMITT. In New Mexico, we have an increasingly underutilized data operation center for social security employer reports. It is as a result of automation. And with that automation, it is my understanding the error rate is going down.

In addition, there is increased capacity. Has there been any thought given to that as one of three regional operations, any thought been given to those centers assisting the States in the processing of records and reducing the error rate?

Mr. SVAHN. Those centers deal with the title II programs which are operated out of the trust funds, and they are wholly dedicated to social security payments as opposed to AFDC payments.

Senator SCHMITT. I understand that, but also we are developing about a 3- or 4-month period of time when they are only three-fourths utilized because of the nature of the workloads for title II processing.

Mr. SVAHN. We have been in the process, Senator, of moving workloads into those data operations centers and moving it out of, say, our Office of Disability Operations, we are decentralizing work into those data operation centers in order to flatten out those peaks of workload that exist there now.

We are in that process and have been reviewing the kinds of things we can do. I don't think that the nature of the error and the operation in the AFDC program could be helped much by utilizing those data operation centers. It is a totally different kind of an operation.

REDUCING ADMINISTRATIVE COSTS AND AFDC ERRORS

Senator SCHMITT. Well, I would like to have a chance to talk with you some more on that. We won't do it here. I think you can see the concern of the subcommittee. We are a little bit incredulous that you can be reducing the overall administrative cost simultaneously with asking for a zero-error rate.

Now, I personally believe that in theory that is possible, but what I am concerned about is the practice. And the individual States, as you have already testified, are very different in their administrative costs as well as their error rate.

Do you suggest there is no systematics, no correlation, that you can see in the data at this time? I would hope that rather than just saying we are not going to participate as the Federal Government in condoning high error rates, we get some imagination and figure out how are we going to insure there are low error rates at the same time there are low administrative costs.

I don't see how you are going to get there from now.

Ms. MCMAHON. We are doing a number of things like working with States on error-prone profiling and wage data exchanges. We have just been working, for instance, with the exchanges between States—Maryland and Virginia, Virginia and North Carolina, and Virginia and the District of Columbia. And we are expanding that operation.

States are finding errors that way. So we are providing technical assistance and will continue to do that. It is definitely a priority.

REDUCING ADMINISTRATIVE COSTS IN OTHER BLOCK GRANTS

Senator SCHMITT. In other programs where you don't have a clear budgetary separation between administrative costs and program costs as you do here, one of the tendencies I have noted in New Mexico is for the savings, so-called savings, in the block-grant approach to be passed on as cuts at the provider level with very little change in the administrative overhead at the State level.

Now, you do have some leverage with this program since it is purely administrative funding that you are talking about here. And you do not have to try to distinguish what is administrative overhead and what is program implementation.

Do you see anything in this activity for AFDC that might be used as a criteria for this committee or for the Congress to apply in these other block-grant programs where it appears that there is a tendency or maybe a tendency by States to not reduce administrative overhead at the State level, but pass on these so-called block-grant savings as cuts to the providers?

Mr. SVAHN. Well, I am not sure that there would be any lesson that we could learn from here that might be applied to other block-grant areas. I have to honestly admit to not being that familiar. I assume we are talking about the area of social services and things like that that are transpiring out there in the States.

There is a general reluctance, shall we say, on the part of the bureaucracy to trim itself down, and that exists in the Federal arena and State level and in local government.

In the area of error rates, we have seen some of the States that do have locally administered programs who have enacted laws whereby they would pass on any reduction to the entity that actually did the eligibility determination and that kind of thing.

MANAGEMENT OF WELFARE PROGRAMS

If I could make one other comment, Senator, the management of welfare programs, if you will, at the State and local level is almost like coming out of the dark ages over the past, say, 8 years or something like that, in terms of moving to a much more manageable kind of operation or much more efficient operation with modern management techniques.

The reason that I personally have been extremely frustrated in dealings with a number of States is that it is so simple for them to reduce errors in some areas by simplifying their programs and by changing the rules and regulations that they operate under.

For instance, Mr. Simmons, my Deputy for Programs and Policy, just pointed out to me that when he was in the State of New York, they reduced their payment error rate in half by one mailing to all recipients. And you think, well, why in the world didn't they do it before.

My answer to that is, "I don't know." I have dealt with a number of States, and it just never ceases to amaze me what a low level of management capability we have in some of these programs.

Senator SCHMITT. It couldn't possibly have anything to do with maximizing the number of State employees employed by State government?

Mr. SVAHN. I did comment it is sometimes difficult for bureaucracy to trim itself; yes.

Senator SCHMITT. Thank you, Mr. Chairman.

Senator CHILES. If you have no other questions in that area, I am going to move on to refugee and entrant assistance.

REFUGEES AND ENTRANTS

All right, moving on then, Mr. Commissioner, to refugees and entrants, your proposed new regulations would cut off cash and medical assistance to refugees after 18 months unless the State had a regular general assistance program.

You base your justification entirely on equity between refugees and the regular population. I happen to think that that justification is totally out of line with the intent of the Refugee Act.

The underlying premise of the Refugee Act is that State and local governments will bear a burden from large numbers of refugees and that the Federal Government should reimburse that burden 100 percent for 3 years.

Now, the question of encouraging people to work; the whole reason that these people boarded the boats and headed for America to start with was to get jobs. But when they get here, they don't speak our language, they don't have the basic education, and they have no useful job skills. They cannot get jobs, and they end up being a burden on the local community in one form or another.

Your regulations don't put people to work. They just shift even more of the burden to the local taxpayers.

The real problem here is equity between the States.

In your response to Senator Hatfield's question in the Judiciary Committee, you stated that five States with 60 percent of the refugees had general assistance program. And therefore, they are not going to lose any reimbursement. But there are four other States with 18 percent of the refugees that have no general assistance program. And they are going to be cut off after 18 months.

That just leaves the cost savings to be borne by a few States with that 18 percent of the share of the total refugees. Is that fair?

Mr. SVAHN. Well, Mr. Chairman, let me just make a general comment, and I will ask Mr. Hawkes who has been resting here and waiting for this part of the hearing to comment further.

You made the comment, Mr. Chairman, that the refugees get on the boats to come to the United States to get jobs. And I am not sure that that is why people come to the United States.

We have, over the past 7 years, had two very large influxes of refugees come to this country. And I use "refugees" in a generic sense as opposed to the legal sense of refugees versus entrants. In the first instance, in 1975, we had hundreds of thousands of Indochinese refugees that came to the United States in a very short period of time because their country's government fell, and they were fleeing. And they were trying to get somewhere other than where they happened to be at that time.

And the United States quickly responded and moved to resettle those refugees within the United States, although they now tend to concentrate in the southern part of California.

In 1980, again, we had a very large influx, as the Senator is well aware, into Florida via the so-called Mariel boat lift. And I am not sure again that those individuals came to this country to get jobs. They came to this country to flee the country that they were in for various reasons.

I have spent, as has Mr. Hawkes, this past 10 or 11 months trying to clean up what we found in the area of refugee management when I was employed and when Mr. Hawkes was employed by the Federal Government. And I must say that it is not done yet. But we are moving in that direction, and we are on our way to do that.

When I became Commissioner of Social Security, we had a Cuban/Haitian task force, we had interdepartmental rivalry and confusion about who was responsible for what in terms of the refugee program. The President established a task force on immigration policy. We have eliminated the Cuban/Haitian task force and have assimilated the work that has been done there.

We have been successful in finally closing the facility at Fort Chaffee and eliminating that. I have been down and have been in south Florida and looked at the problems that have been created there, as has the Vice President. And I indicated that the Vice President, upon coming back, established a special task force under Admiral Murphy, one of his assistants, to look at ways that we could solve some of the problems that we found in south Florida.

And, as I indicated before, we are prepared to provide a $35 million program to take care of some of that impact that has been caused in south Florida and a $1 million special grant to resettle some of those people out of south Florida.

So we have a bad situation. There is no question about it. But we are working to alleviate that situation.

And now I will ask Mr. Hawkes to respond specifically to your question about the general assistance impact.

Senator CHILES. Well, my concern is, let's take an Indochinese refugee. If he goes into California, he is going to get general assistance. If he goes to the State of Oregon, he is not. And the burden for him is going to fall on the State of Oregon. Why should that be?

Mr. HAWKES. Mr. Chairman, first of all, we will continue to reimburse 100 percent for all those refugees and entrants that meet the categorical requirements of AFDC programs. There is no backing away from that. The only ones that we are talking about are those that do not qualify for AFDC.

And in those cases where they reside in States, cities, or counties that have general assistance programs and if they qualified for those programs in exactly the same manner as a citizen does, then they are going to get that general assistance whether we reimburse or not. And all we are offering to do in this case is to reimburse the expenses of that general assistance program in those areas.

We believe that only about 10 percent of——

Senator CHILES. It is not a question of what you are offering to do; it is what you are reneging on. You are reneging on a 3-year proposition of saying to the States, "We are going to give you funding for 3 years to be able to assimilate the refugees and those that don't have a general assistance program."

You are reneging on 18 months of what is the law set forth by the Congress. And you are doing it with a regulation.

Mr. HAWKES. Senator, there is more to it than that, though, because what happened just as a result of that act in that 36-month Federal reimbursement, that was taken by refugees to mean that they had an entitlement for 36 months. And our rate of refugees on assistance went up to 67 percent by the end of the last fiscal year.

Refugees were coming from the camps with the expectation of taking 3 years to educate themselves to learn about America. And even some of the voluntary agencies and service providers were developing 30-month plans to implement to bring somebody up to speed.

Senator CHILES. I don't know where those figures come from. In Florida, it is 35 percent.

Mr. HAWKES. I beg pardon?

Senator CHILES. In Florida, it is 35 percent.

Mr. HAWKES. Nationally, it was 67 percent, sir.

Senator CHILES. Well, what is going to stop that from happening in California? What have you done to stop that? If you want to start talking about how you are going to stop that across the Nation, I will listen to you, I will listen to everything you have to say, but why are you going to allow it in California, yet you are going to stop the State of Oregon from being reimbursed? In the Miami area, you are stopping the State of Florida.

Mr. HAWKES. Well, the impact aid program that will affect principally Florida will offset a very large amount of the money that would have flown to refugees on an individual basis in terms of AFDC.

In California, the most needy will be picked up by general assistance. In Oregon, there is no general assistance program. A large portion of people there will remain without assistance of any type. We are working with the voluntary agencies and service providers to get ready for that.

And we have tried to send out the word that things are going to change. But it had to change. We have cultural orientation programs funded by the State Department taking place in the camps, telling people this is not an entitlement; you have come here to work.

We are working with it at a number of levels, but there is no way to cut it off without causing some hardship.

I don't think we are transferring a large number of costs directly to States even those that don't have general assistance programs.

Senator CHILES. You don't think that? Have you talked to the officials from the State of Florida? Have you talked to anybody at Jackson Memorial Hospital as to what the burdens are?

Mr. HAWKES. Certainly. And we have worked through the State of Florida to fund Jackson Memorial. We have been granting money for those costs.

Senator CHILES. I have to say I think your proposed interim regulations, that you have talked about this morning, certainly will be of assistance to us and certainly being able to get a service contract is going to be a great help.

The way I understand it, that will be a help to Jackson Memorial to pick up these costs. And in effect, you have added $15 million. That is a net result, really, of what we are talking about.

Mr. SVAHN. Above the $20 million?

Senator CHILES. Above the $20 million, bringing the total up to $35 million.

Mr. SVAHN. Yes, sir.

Senator CHILES. Now, as to your new interim final regulations, would you describe the consultation process and what services will or will not be allowed under those regulations?

Mr. HAWKES. What we did was to make the decision, the Secretary made the decision, to issue the 18-month policy as an interim final and hold broad consultations with all interested parties as to how we should treat the second 18 months.

We are fairly restricted because we have a gas problem. We have a limited amount of money to spend during that second 18 months of eligibility. What we have done was to hold a series of regional meetings in the 10 Federal regions, asking States to send representatives and to discuss that second 18 months.

We are now holding a meeting Friday with representatives from all States to discuss the results of the local meetings. We are also meeting with mutual assistance association leadership nationally and with voluntary agency leadership.

The commitment here is that if those people can determine a better way to treat that second 18 months within the limits of our budget, we would be very happy to consider that.

Senator CHILES. I am pleased to see that you have responded to our committee report language by developing this so-called targeted assistance to areas of heavy impact.

I am also pleased that you have announced that you have increased that $20 million to $35 million for this year. Will the same amount be proposed in fiscal year 1983 as well?

Mr. SVAHN. Well, Mr. Chairman, we have proposed at the present time $20 million for special impact assistance in fiscal year 1983.

Now, as I indicated before, the Vice President has set up a special task force. This is the first announcement that has come out of the work of that task force and as a result of the Vice President's trip to south Florida.

At the present time, our request is for $20 million. I cannot say what we are going to do before then.

Senator CHILES. Well, of course, that will cover not only Florida, but that could cover Indochinese as well; is that correct?

Mr. Svahn. Yes; that's correct.

Senator Chiles. Well, again, if it is going to really provide us the assistance and make up the gap in this 18-month cutoff, we will need additional funds for 1983 as well as for 1982.

Mr. Svahn. Well, Mr. Chairman, I think that we recognize, and I think that the Vice President's trip and his special task force on the problems of south Florida recognized, that there is a situation in south Florida where we do have a responsibility. And I feel certain that the administration will meet that.

I am not at liberty at the present time to say what it is that is going to be done. I don't know what will be done. I do know that we have made the decisions on the special impact aid and on the resettlement program, and I feel competent that more will be forthcoming.

Senator Chiles. I want to set the record straight on how broad and flexible the targeted assistance program will be. The State of Florida has documented $149 million in unreimbursed Cuban/Haitian costs since 1980. Of that, $61 million was borne by the State and $88 million by local governments.

Obviously, we don't have enough money to come close to closing that gap. Will the targeted assistance grant be able to cover costs like criminal justice where there are almost $15 million of unreimbursed cost?

Mr. Svahn. We have not spelled out any detail, Mr. Chairman. As I indicated, the program itself will be announced in the Federal Register on Friday. We have not spelled out any detail, but it is geared to relieve those costs at the local level which have been caused by high concentrations of entrants for this year.

And I don't know. Phil, do you have anything else to add to that?

Mr. Hawkes. No.

Mr. Svahn. As I said, I have been to south Florida, have met with local officials there. And I know what their estimates of costs are.

Senator Chiles. Will we be able to get a general contract to Jackson Memorial Hospital to serve Cubans and Haitians and get them away from the case-by-case redtape which has left them holding the bag for about $6 million worth of medical care?

Mr. Hawkes. Senator, I don't know exactly how Jackson Memorial reimbursement will work out. We realize that is a big problem. We have been working with that hospital through the State for several months now to backpay for costs that Jackson Memorial has been accumulating over the last year.

Senator Chiles. For example, you had regulations that say if you don't have a social security number, you cannot be paid. That is a catch-22.

Mr. Hawkes. We changed our regulations, sir, to meet those particular requirements of south Florida and to cover the entrants that are known to INS, and even as broadly as we possibly could. We took the act, the Refugee Education Assistance Act, and interpreted that as broadly as possible to cover the broadest possible range of Jackson Memorial costs.

We are trying to work with the hospital to offset these costs and not leave the county and the citizens down there holding the bag.

Senator CHILES. Will Florida be able to pay for adult education and job training so that the people can become self-supporting?

Mr. HAWKES. Sir, within the impact aid program, the guidelines of how that money will be used are very, very broad. I cannot tell you right now at this point what the limitations are, but it is a very broad program. There is a wide range of allowable costs, and we are expecting that the State or localities through the State will develop proposals to spend this money in ways that directly affect the entrant population.

And we would expect to tack on those very quickly.

Senator CHILES. In fiscal year 1983, you are proposing to cut assistance to areas with Cuban and Haitian entrants down to $17.3 million from the $90 million that we have this year.

The State of Florida estimates that they will not have a significant decline in caseload. They tell us that while many adult males are going to work, they get increasing numbers on welfare as the young mothers have more children.

When we were writing the reconciliation bill last year, the Congressional Budget Office, after consulting with your department, developed an independent estimate of $53 million for cash, medical, and social services for fiscal year 1983. We wrote that level plus $6 million for education into reconciliation, and the President signed that into law.

You now want to go beyond cutting from $94 to $59 million which is already a 37-percent cut and go all the way down to $17 million. That would be an 80-percent cut from this year to next.

What do you think is going to happen to make that problem disappear or 80 percent of that problem disappear?

Mr. HAWKES. Senator, a couple of things affect this. The Mariel people who came in in 1980 will be time expired on the 3-year Federal reimbursement limitation during fiscal 1983. So they will move into the matching program the same as other people on AFDC.

Also, I am not sure, but I believe—no; I will hold my answer.

I believe that the children born in this country are U.S. citizens. I am not sure how the refugee program reimburses that.

Mr. SVAHN. Well, they are U.S. citizens.

Mr. HAWKES. They are U.S. citizens so they don't fall into the refugee category in that case, the ones that are born here.

Senator CHILES. You mean that Jackson Memorial, when the mother goes into the hospital and has a baby doesn't charge anybody because they are a U.S. citizen?

Mr. HAWKES. That cost is borne by the AFDC for the child. The child is a U.S. citizen.

Senator CHILES. But the mother gets support under AFDC, does she not?

Mr. HAWKES. The mother is entitled——

Senator CHILES. We give the check to the mother, don't we?

Mr. HAWKES. The mother is entitled to reimbursement under the AFDC program.

Senator CHILES. I didn't know we gave the check to the children.

Mr. HAWKES. I am sorry, Senator. OK, the mother is eligible, will continue the costs up to 3 years. We will reimburse under the refugee program even for the citizens.

Senator CHILES. Well, your budget estimate is based on 9,000 new Haitians in 1981 and none in 1982. INS tells us you actually got 11,500 Haitians in 1981, 29 percent more than you projected. And so far in 1982, we have 452 new Haitians. That means that the problem is going to remain in 1983 since it takes time to get those people self-sufficient.

And, of course, we are talking now about the officially registered Haitians and not those numbers that keep coming out of the woodwork that we know are there.

Mr. HAWKES. Yes.

Senator, as Mr. Svahn said, he has been to south Florida; I have; the Vice President has. We realize there is a mixup down there of legal and illegal entrant and nonentrant population. We are restricted by legislation to offset those costs only for those people that are known to INS. And we are interpreting that as broadly as we possibly can. But we cannot legally go beyond that.

Senator CHILES. Well, I still think your estimating is way, way off if you are talking about an 80-percent reduction in what the cost is going to be and figuring your numbers on that. I don't see how you come up with some 80-percent reduction given that some of the Mariel people will be going off it even in 1983.

How many months in 1983 will they be on?

Mr. HAWKES. Well, they came in between, what, April and September 1980. And the majority of them will go off then during the fiscal year. The greatest majority of them will be time expired.

Senator CHILES. Well, so they would be on from September 1 to at least April during the year?

Mr. HAWKES. Our estimates show that the $17 million will be adequate to reimburse the State of Florida for their AFDC costs.

Senator CHILES. You never had to change your estimates before on these funding requirements, I take it.

Mr. SVAHN. No, we just make new ones, Mr. Chairman.

Senator CHILES. Yes; well, I have whipped that one about as much as I can.

I find it amazing also that you propose to entirely eliminate educational assistance for all refugees and entrants. So far, there has been less than $300 of assistance provided per pupil. The actual cost to Dade County is almost $1,000. This is not a cost that disappears in 1 or 2 years.

The youngest children will be in school for 12 years. And when you put 16,000 kids into one district as we have done in Dade County, you totally disrupt the system. You can't build 16 schools at once, so the whole system had to go on double sessions.

They needed special teachers, extra support staff, extra security, and maintenance costs. And those costs aren't going to disappear in 1 or 2 years. In fact, in the first quarter of this fiscal year, Dade County enrolled another 420 Cuban and Haitian students.

If that rate continues all year, that will be 1,680 students. That is almost two schools' worth. It would take an extra half million dollars to pay the same $300 per pupil that they get now which again is less than one-third of the actual cost.

How do you justify your proposal to cut off educational assistance short of 3 years?

Mr. HAWKES. The education assistance money was targeted for startup costs and for program development. It was never a belief that $300 a pupil would pay the total costs of educating those students through 12 years of their education.

We would also hope that that large portion of the Cuban entrant population that is not on assistance is in fact employed and paying taxes. I don't think that the 100 percent of the costs of that program is not reimbursed in some way.

Senator CHILES. Mr. Hawkes, you are straining. You have told us that we don't want these people to just feel like they can just go on the dole and stay there forever. You wouldn't claim that about a kid that we are putting through school for a couple of years to try to assimilate him. Do you think he will totally be assimilated in 2 years, 3 years?

Mr. HAWKES. No, sir; but what we hear about and are dealing with today is the portion of the population that is on assistance. That is 67 percent nationally of all our refugees. And many of those are, in fact, working and receiving supplements to their income.

Senator CHILES. What we are really dealing with in the Refugee Act is because of Federal policy. We have dumped these people into a local area, in a very concentrated area. We have dumped these thousands of people because of Federal policy or the absence of Federal policy and it shouldn't be a burden that the State and local government has to totally pick up.

Now, we see from the cost here how much State and local government is having to pick up. With all of the programs that we have got, they are not being reimbursed anywhere near the percentage. But we had a program that said, "We are going to give you one-third of that extra cost that is costing you to educate that child, that $300 assistance."

And now, you propose to cut that off short of the 3 years.

Mr. SVAHN. Mr. Chairman, I think that you hit very well on a topic there when you said, "Because of Federal policy or the absence of Federal policy." And I wouldn't want to get into decisions that have been made in the past. But I think, Mr. Chairman, that Mr. Hawkes and myself recognize the problem that we have in south Florida.

I think that the Vice President recognizes that problem. And what I am saying to you is that we as the executive branch of Government are looking at that right now. We have made some decisions which are going to benefit the area of Dade County.

And I am saying that we will continue to look at it. And the Vice President's task force will continue to look at it, and we recognize that there is a responsibility, there has been a responsibility. The first wave of refugees who resided in south Florida have been assimilated into Dade County. That came in the early 1960's. And they have been an asset to Dade County.

Senator CHILES. They definitely have.

Mr. SVAHN. And we will work to remove that burden that is not the responsibility of Dade County and will continue to work with the Vice President's task force to come up with policy choices.

Senator CHILES. Again, I think everybody has to recognize that that has happened, but we are talking about 20 years later. That has happened over a period of 20 years.

And the other thing I think we have to recognize that is just so true is that the first people that fled Cuba were the doctors and lawyers, the business leaders, the people at the highest educational strata in the main. And now, in the Mariel boat lift, we find a totally different mix, and much of which was at Castro's own direction of taking out the halt, crippled, lame, maladjusted, in some instances even criminals, and sending those over. So you have got a different mix entirely.

Mr. SVAHN. I understand that.

Senator CHILES. Many of those people are trying very hard to bring themselves into the community and seek work. And those are the people that we are attempting very hard to assist.

Mr. SVAHN. I understand that, Mr. Chairman. I was not involved with the initial movement of refugees from Cuba into Florida back in the early 1960's, but I was involved with the evacuation and movement of Indochinese refugees into this country in 1975. We found the same thing.

The difference, I think, is that by the time 1975 came around and thereafter, we have established, as Mr. Hawkes said, a policy which now is guaranteeing if you will an entitlement to 3 years of assistance.

And what we found in the Vietnamese population is the initial people who came into the country were interested in going to work and wanted to assimilate themselves rapidly. And, in later years of Indochinese refugees, we find that in fact people are in camps in the southeast area somewhere, and they are filing applications for admission to U.S. universities in anticipation of coming in and remaining for 3 years on refugee assistance.

So you are correct, it is a different group in both instances.

Senator CHILES. I also want to make sure that you are not trying to cut funding for Cuban/Haitian domestic assistance and use it elsewhere despite congressional intent in the appropriations act. We appropriated $94 million for domestic assistance of which $88 million is for cash medical and social services; $6 million is for education assistance to Dade County.

Our committee report directed you to use the funds available within the $88 million plus any available carryover funds to pay for targeted assistance.

Your budget justification shows that you have allocated the correct amount after the 4-percent cut; $90.2 million for domestic assistance and $19.2 million for reception and processing. Yet, we keep hearing rumors that OMB wants to shift $27 million out of domestic assistance and spend it on reception and processing—that is, for the cost of running the camps.

Can you assure us that all the funds appropriated for the Cuban and Haitian domestic assistance are going to be spent for that activity?

Mr. HAWKES. Senator, we would be expecting to ask to reprogram $13 million to reception and processing.

Senator CHILES. From domestic assistance?

Mr. HAWKES. Yes, sir.

Senator CHILES. Well, if you are going to expect to ask that, I hope you won't expect too much support for that from the committee. You don't need to spend that on domestic assistance.

Mr. HAWKES. No, sir; not with our policy changed and our impact aid program.

Senator CHILES. It is interesting because you just told us, Mr. Hawkes, we can't afford to do much of this. You even talked about the consultation process. But you said we are going to be handicapped by a shortage of funds.

And here, Congress has appropriated the funds, appropriated the money, for domestic assistance, but you are going to change your regulations so you cut that money. Then, you are going to use it for camps.

Mr. HAWKES. Mr. Chairman, the law requires us to treat Cuban/Haitian entrants and refugees comparably. We developed a policy of eliminating special refugee assistance, therefore special entrants' assistance after 18 months.

We developed an impact aid program targeted to entrants that picks up about the same amount of money that is saved by that policy in the entrant program and targeted it to entrants that reside principally in Florida.

We at the same time handed over the responsibility of reception and placement of the remaining Cubans in custody. That task has been given to the Justice Department. The Justice Department needs an additional $13 million down from the original estimate of $28 million to carry out that for the remainder of 1982.

We would hope to ask to reprogram that money for that purpose.

Senator CHILES. Well, we look forward with great interest to seeing that reprograming.

States complained to Congress loudly and regularly that they are having trouble getting their quarterly apportionments for the refugee and entrants programs in a timely manner. How do you respond to that criticism?

Mr. SVAHN. Well, I joined in that complaint myself, Mr. Chairman. And perhaps Mr. Itteilag would want to comment on that process.

We make the request in a timely fashion. And sometimes in the past, we have not gotten the apportionment in a timely fashion, but is there something you want to add to that?

Mr. ITTEILAG. Only, Senator, that this, among other matters, is the type of thing that we engage in debate with with the Office of Management and Budget. And from time to time, funds are held up to an extent that we would not ordinarily approve of. But it is a matter of getting the money approved, a somewhat complicated process. And we do push to get it done as quickly as possible.

Senator CHILES. Last year, it took 6 months, and that really is amounting to a deferral. Jackson Memorial was virtually bankrupt, and some of the other institutions down there because of the delay. It is kind of bad when the Government gets the reputation for no pay or slow pay.

Mr. ITTEILAG. That is correct, Senator.

As I said, we do the best we can under those circumstances. And I must say it would be helpful if others recognize that the problem is not solely within the Department and from time to time directed their attention to other parts of the executive branch.

The fact of the matter is, as you well know, under the law, we simply cannot spend that money until we have approval of the Office of Management and Budget.

Senator CHILES. Well, I think it might be helpful if you would notify the subcommittee every time you make an apportionment request and then allow us to determine who else is slowing that down.

Mr. ITTEILAG. I don't see that there would be any problem in doing that on an informal basis.

Senator CHILES. That's interesting to note that on two occasions now we have had to ask for a GAO study to get anything to happen. Once the study starts, by golly, sooner or later, that money gets paid, gets cleared up, and they report back to us that, well, they can't really say there was a deferral because the money got paid, but nothing happens until you get them looking.

Well, let's discuss the funding for social services. In the case of refugees and entrants, social services funds have a very narrow use: They go to train adults in basic English language and vocational skills necessary to get jobs. The Department tries to justify its new regulations on the basis of employment incentives but, at every turn, you try to cut back the funds that would enable entrants to become employable.

Looking at the regular refugee program, GAO reports that for the first half of fiscal year 1982, you only apportioned one-third of the funds appropriated for social services while you apportioned 53 percent of cash and medical.

GAO states, "The apportionment requested by the agency was not sufficient to satisfy the States' requests."

While they found that you didn't technically break any laws, you have clearly used the deferral procedure to shift funds away from social services into cash and medical. When you released the $10 million of 1981 deferred funds for social services, you reduced the 1982 allotment by that same amount.

How do you expect these people to get jobs and get off of welfare if you keep cutting back on the English language and the vocational training?

Mr. SVAHN. Well, Mr. Chairman——

Senator CHILES. This would be exactly what Senator Hayakawa was talking about as well, I think.

Mr. SVAHN. It is interesting, yesterday, Mr. Chairman, in the other body, before an appropriations committee, I was trying to explain why it was we were spending money on social services because their committee investigation report had just turned up the startling conclusion that we have no evaluation or no recognition that social services do anything to help refugees get employment or to acclimate themselves to the United States.

And I think the conclusion that I draw is that we don't have any evidence other than just a belief or a commonsense feeling that if you provide English as a second language or if you provide some other kinds of social services that that is going to do anything.

Senator CHILES. English as a second language in this country? I mean, you are sounding like we don't need to provide a second language to somebody that already comes here with a language. My golly.

Mr. SVAHN. No, what I am trying——

Senator CHILES. I don't think it is a frill we are giving to teach people English. Second language sounds like to me that is a frill.

Mr. SVAHN. No; that is the bureaucratic term of art for teaching people English, people who speak a different language. I believe that a person——

Senator CHILES. How can they get a job if they don't speak English?

Mr. SVAHN. Well, that all depends on where they live, Senator. I believe that—and I happen to agree with Senator Hayakawa—English should be our principal language in this country. But for individuals who come here, sometimes it is a second language.

Our problem—and this is one that we face in all areas of social services, not just social services of refugees—is that we can't demonstrate, and it is not only demonstrate to the Congress, but it is also within the executive branch, we cannot demonstrate the effectiveness of social services in doing anything, whether it is getting a job or acclimation to this country or anything else.

We cannot demonstrate that. And so we have a very difficult time in trying to justify a large budget for social services when all we can say is, "Look, we know it does good."

Senator CHILES. Well, so because you can't seem to demonstrate it, don't you think that we should pay anything for vocational training for the entrants that are coming in?

Mr. HAWKES. Mr. Chairman, another part of the social services budget is that the social services money is predicated on the number of refugees that enter each year. Last year's budget was based on an expected population of 168,000. And we received 132,000, using the Indochinese numbers.

This year's budget was originally described to pay for at least 100,000, probably more than that, and we are currently expecting considerably less.

So actually, in terms of money expended, we are staying fairly even. Our per capita expenditures are even.

Further, we have been working with States, a State plan that is required by the Refugee Act. We have been looking particularly at what services are provided. And the majority of money is being spent for English language and vocational training, two things that we think are the most effective.

Senator CHILES. Senator Hatfield had a question. What does the ORR plan do in fiscal year 1982 for States like Oregon and Washington? How are these States supposed to cope with medical and educational costs?

Mr. SVAHN. I think that Senator Hatfield's question relates to impact aid and what are we going to do in light of the change in regulations for the State of Oregon and the State of Washington.

And the impact aid, as the chairman recognizes, for fiscal year 1982 is geared only toward entrants and not toward refugees. So to the extent that there are concentrations of entrants in those States, then they would be eligible for impact aid.

Now, as the chairman knows and I know, there aren't concentrations of Cuban/Haitians in Oregon and Washington. And the answer to the question is not——

Mr. HAWKES. Let me elaborate just a little. It might be a little better than nothing.

Both Oregon and Washington are sending representatives to our meeting Friday to discuss the second 18 months and the money that is available and how it might best be used. And we would appreciate input from those as well as others.

Outside the medical rank because, I can't quite touch that, but within the discretionary portion of the social services money, we are looking particularly at one of Senator Hatfield's concerns which is preliterate people. And we would hope to be able to work out some targeted assistance for preliterate people, especially. And especially Oregon has a large population.

Senator CHILES. Do you have any evidence to show that any money we would ever spend on literate people would ever do anything?

Mr. HAWKES. Senator, we have some of the other kind of evidence. We know that refugees that do speak English have a lower unemployment rate than the population of the United States at large. And we know that those that can handle English have a much higher unemployment rate so, indirectly, we know our English-as-a-second-language programs pay off.

Senator CHILES. That would tend to justify some expenditure of funds under the social services program, wouldn't it?

Mr. HAWKES. Yes.

Senator CHILES. Well, we thank you for your appearance here today and your testimony.

We are delighted to hear of the changes that have been made in regard to the change from the $20 million to the $35 million in the targeted special assistance.

Mr. SVAHN. Thank you, Mr. Chairman.

SUBMITTED QUESTIONS

Senator CHILES. There will be some written questions for the record.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

SSI-ASSET DISPOSAL

Question: What has been the effect of the recently enacted law which limited eligibility for Supplemental Security Income and Medicaid for individuals who dispose of assets in order to make themselves eligible for these programs?

Answer: For the SSI program, the enactment of P.L. 96-611 changed the rules used in determining countable resources for establishment of eligibility. Under this law, the value of any unexcluded resources which an individual or couple may have disposed of within two years of filing for benefits is considered in determining eligibility for SSI. In determining the value of the disposed resources, SSA considers the fair market value of the resource less any reimbursement.

The law was implemented in March 1981 and has resulted in claimants being denied who, under the prior law, would have been eligible. SSA also believes that the publicity surrounding enactment of this legislation has discouraged others from filing. The Office of Research and Statistics estimates that 1,700 claimants have applied for SSI benefits and been denied under this provision.

ERRONEOUS PAYMENTS IN THE DISABILITY PROGRAM

Question: What are the Administration's current estimates of the level of erroneous payments being made in the Social Security Disability program, and what steps are being taken to reduce this amount?

Answer: The latest overall payment error rate for the Social Security Disability program is 27.8 percent of all benefits paid to disabled workers in current pay status. Medical factors represent 27.4 percent and nonmedical factors account for 0.4 percent. SSA has two major initiatives in place to reduce this error rate: pre-effectuation review (PER) of State disability determination agency decisions, and periodic review (CDI's) of disabled beneficiaries currently on the rolls.

Pre-effectuation review requires a Federal review of specified percentages of State disability allowances prior to payment action in initial, reconsideration and continuation determinations. SSA also is required to review the continuing eligibility for disability benefits of all non-permanently disabled disablity insurance beneficiaries every three years under the CDI initiative. We are extending this review to Supplemental Security Income disability cases in addition to the title II cases required by law.

The President's budget contains the following resources for these two initiatives:

	FY 1982 Estimate		FY 1983 Estimate	
	$ (in millions)	Federal Work-Years	$ (in millions)	Federal Work-Years
Pre-effectuation review..........	$21.1	404	$22.8	442
Continuing disability investigations (DI and SSI initiatives).....	155.8	1,880	272.5	3,009
Total.........	$176.9	2,284	$295.3	3,451

Question: To what extent are these cases with erroneous payments responsible for the backlog of disability cases at the hearings level and what is being done to reduce this backlog?

Answer: Appeals of decisions to remove ineligibles from the rolls through continuing disability investigations (CDI's) contribute significantly to projected hearings backlogs. Our latest estimates for CDI-related hearings requests are 58,400 in FY 1982 and 125,300 in FY 1983. This represents 20 percent and 30 percent of all new hearings requests in each year, respectively.

As indicated in SSA's budget request for 1983, we will be making an effort to control the hearings backlog. We plan to hire 74 additional administrative law judges (ALJ's) by the end of 1982 specifically for the CDI-related hearings workload. We also plan for more and better use of hearing office support staff, greater use of word processing equipment and increased training for both ALJ's and support staff.

SSI-DISABILITY

Question: Why are the disabled such a large part of new enrollees in the Supplemental Security Income program?

Answer: We are not sure of all the reasons, but one of the major reasons that we know contributes to this pattern is that Social Security benefits, on the average, are increasing faster than the SSI Federal income guarantee. Since a larger proportion of aged recipients than disabled recipients receive title II benefits, the faster rate of increase in title II benefits has increased the incomes of the aged to the extent that fewer are eligible for SSI benefits. Blind and disabled SSI recipients on the average do not have as close an attachment to the workforce as do aged recipients. Therefore, the disabled recipients are less likely to have Social Security benefits or other sources of income that would affect their SSI eligibility, and the number of disabled recipients is more likely to rise than aged recipients.

Question: Since October 1, 1981 the law has allowed the Secretary to reimburse State vocational rehabilitation agencies only for services provided to disabled SSI recipients who subsequently perform substantial gainful activity that lasts for a continuous period of 9 months. How does this affect State rehabilitation programs?

Answer: Funding for the SSI rehabilitation program totals $1.5 million in 1982 and $3 million in 1983. These amounts represent a reduction from the $37 million provided to the States in 1981 under the old program. We anticipate that reimbursement will be provided in far fewer cases because of the more restrictive definition of rehabilitation and because the previous authorization permitted expenditure of SSI funds for services which did not always lead to successful rehabilitations. However, the States can continue to serve SSI recipients under the basic State grant program, since these individuals are among the most severely disabled and should receive priority consideration under that program. If the number of successful SSI rehabilitations should prove greater than expected, we can obtain additional resources by reprogramming or requesting additional funds.

CHILD SUPPORT COLLECTIONS

Question: Estimates of Federal collections in fiscal year 1982 under the Child Support Enforcement program have dropped from $371 million to $323 million. What accounts for the reduced revenues you expect from collections in this program?

Answer: The collection estimates were lowered due to three factors. First, the actual 1981 collections per case were lower then estimated. Second, we revised the estimate of caseload as a result of changes to the AFDC program contained in the Omnibus Budget Reconciliation Act of 1981; and third, we have revised the estimated impact of the Child Support Enforcement provisions, also part of last year's Omnibus Budget Reconciliation Act. However, I would like to point out that the $323 million in estimated collections is more than a 20% increase over the 1981 actual collections.

SSI ESTIMATES

Question: The budget estimates for SSI assume that approximately 385,000 new beneficiaries will come on the rolls in FY 1983, while 320,000 will drop off the rolls in the same time period, due to "normal attrition". How are these estimates calculated?

Answer: SSA's Office of Research and Statistics (ORS) is responsible for estimating beneficiary caseloads for the SSI program. ORS monitors a variety of data sources and revises its estimates periodically to reflect recent experience. First, the number of people who move in and out of payment status from month to month must be determined. Such movement may be caused by death, cessation of disability, temporary additional income, etc. Based on a close examination of both the number of applications filed as well as the acceptance/disallowance rate, ORS estimates the number of recipients added to the SSI rolls. Routine closings and administrative closings through the redetermination process provide data on the numbers leaving the program. Beneficiary estimates for any month are dependent upon the estimates for previous months. While each month is calculated separately, the fiscal year estimate is determined by the aggregate of all the months in the year.

Question: How accurate have SSA estimates of the number of beneficiaries been over the last four years?

Answer: The following table displays the SSI caseload estimates calculated by the Office of Research and Statistics by year for the period FY 1977 through FY 1981 as contrasted to the actual for each year:

	Average Monthly Federal SSI Recipients				
ORS Estimate (year in which estimate is prepared)	FY 77	FY 78	FY 79	FY 80	FY 81
FY 77	3,877,000	3,905,000	3,915,000	---	---
FY 78	---	3,793,000	3,778,000	3,793,000	---
FY 79	---	---	3,710,000	3,705,000	3,725,000
FY 80	---	---	---	3,697,000	3,679,000
Actual	3,790,000	3,782,000	3,700,000	3,700,000	3,663,000

RETROSPECTIVE ACCOUNTING

Question: The Omnibus Budget Reconciliation Act of 1981 mandates that retrospective accounting be used to determine both AFDC and SSI benefits. This means that benefits should reflect the circumstances of the beneficiary in the previous month and that the beneficiary's statement of these circumstances should be periodically checked. What is the status of implementation of a retrospective accounting system?

Answer: For the SSI program all necessary work is on schedule in order to implement retrospective accounting in April 1982 as required by law.

As of March 1, 1982, 23 States and jurisdictions have implemented retrospective accounting systems for AFDC benefits. One State--Indiana--was granted a waiver on its implementation date. We expect the remaining States and jurisdictions to implement their systems this fiscal year.

Question: How much money is the requirement for retrospective accounting supposed to save in fiscal year 1982? In fiscal year 1983?

Answer: As the law is presently worded, retrospective accounting in SSI will cost $30 million in FY 1982 and $5 million in FY 1983. However, if the Administration's proposed technical amendment to coordinate cost-of-living adjustment increases in the SSI and OASDI programs is enacted, we estimate that retrospective accounting in SSI will result in savings of $20 million in FY 1982 and $40 million in FY 1983.

In the AFDC program, it is not possible to estimate separately the impact of retrospective accounting because it is linked to the requirement for monthly reporting. Because of the nature of the data on which the estimates for retrospective accounting and monthly reporting were made, it is not possible to produce separate estimates for each requirement. Net savings for the dual requirements are projected at $55 million in FY 1982 and $171 million in FY 1983.

STATE ADP SYSTEMS

Question: The Federal Government is funding State automated data processing systems under various Federal programs. Has HHS or any other Department prepared a comprehensive inventory of State ADP systems?

Answer: The Office of Family Assistance, Social Security Administration, HHS has collected an inventory of State ADP systems used to administer the Aid to Families with Dependent Children (AFDC) program. The inventory is useful but it is not entirely comprehensive because the data have been gathered by OFA staff based on review of documents submitted by States and site visits to State agencies. Such information, using OMB's paperwork burden reduction guidelines, would not be obtainable directly from States. The OFA inventory is more descriptive of systems functions and processes than equipment hardware.

Question: How many existing State systems are already paid for by the Federal Government?

Answer: States are entitled to matching Federal funding for the development of automated systems or the acquisition of ADP hardware and software used in the administration of the AFDC program. State automated systems vary widely in size and scope and are continually modified, augmented or optimized. The Federal Government continues to share in the cost as enhancements are made. Thus, every State has claimed some Federal funding for systems. In addition, recent legislation intended to encourage systems development in the AFDC program provides 90 percent Federal matching funds for comprehensive statewide systems.

Question: Has HHS analyzed the cost-effectiveness of these expenditures? What is the result of this analysis?

Answer: Total expenditures for State systems are not available since they are included with all other administrative costs in financial reporting of expenditures. However, ADP costs are not allowable without prior approval and States do submit estimates of savings and benefits when requesting funding for such activities, and they are generally cost justified.

Four States recently approved to receive funding to develop comprehensive automated systems reported the following:

($ in millions)

	Development Costs	Projected Annual Operating Costs	Projected Annual Savings
Colorado....................	$4.3	$1.2	$3.4
Utah........................	.9	.4	1.4
Missouri....................	1.1	2.5	2.6
Washington..................	3.3	3.2	7.3
Total.....................	$9.6	$7.3	$14.7

These four States project annual savings of $14.7 million versus annual operating costs of approximately $7.3 million per year.

Question: Is there strong evidence that these State ADP systems are helping to reduce waste and fraud in the Assistance Payments Program? Cite specific evidence.

Answer: Yes, there is strong evidence. Here are some examples:

The New Jersey Division of Public Welfare recently matched its active AFDC and Food Stamp cases against the employee earnings file of the Division of Taxation. As a result, of 49,000 matches, 29,000 were referred to local welfare agencies to determine current employment status, amounts of overpayment and the extent of fraud. The State projects savings of about $8 million from this activity.

OFA has recently facilitated exchanges between the District of Columbia and Maryland, the District of Columbia and Virginia, Virginia and North Carolina, and is currently working to establish an exchange between North Carolina and South Carolina.

In March 1982, Virginia and North Carolina matched their AFDC rolls and North Carolina's AFDC rolls against the Virginia Employment Security Files. Preliminary unverified statistics show 16 matches of individuals on the rolls in both States and 352 North Carolina recipients receiving wages or unemployment benefits in Virginia.

In addition to automated comparison of State welfare rolls to State and Federal Government employee wage files, the Office of Family Assistance (OFA) is encouraging States to use automated techniques to obtain and exchange data to verify the eligibility of AFDC recipients. Data on wages, Social Security and unemployment benefits, motor vehicle registration, and school attendance are a few examples.

Computer matching has been so effective at detecting fraud - recovering an average $7 for each $1 spent - that President Reagan's Council on Integrity and Efficiency has created a separate Long-Term Computer Matching Committee to encourage more computer investigations.

EMERGENCY ASSISTANCE

Question: Last year, the Administration proposed to consolidate the Emergency Assistance program with the Low Income Energy program. Congress rejected this proposal. Now for fiscal year 1983, the Administration is again recommending the same consolidation. How are States currently using the Emergency Assistance program? How many States participate in it?

Answer: Under current law, States can spend Emergency Assistance funds for any emergencies involving needy families with children. Twenty-six States and two territories are participating in the program with funds going for a wide variety of purposes. This includes emergency assistance for rent, clothing, food, appliances, fuel and electricity, medical care, and emergency shelter.

Question: Based upon what evidence does the Social Security Administration believe that States will reserve part of their Low Income Energy money for Emergency Assistance purposes?

swer: Twenty-six States are currently participating in the AFDC Emergency Assistance program which contains a match requirement and numerous regulations. We expect that with decreased regulations and requirements and with no match requirement there will be increased State participation in emergency assistance activities.

Question: Does SSA plan to require States to reserve part of this block grant for emergency assistance?

Answer: States will not be required to reserve a portion of their energy and emergency assistance block grant allocations for emergency assistance. We continue to believe that it is more appropriate for States to make such decisions based on their individual needs and priorities.

Question: Given the fact that Congress rejected this proposal for consolidation last year, why do you believe it will enact it this year?

Answer: We believe that the proposal to combine energy and emergency assistance is in keeping with the emphasis to return program decisions and management to the States; that it is in the interest of a balanced budget; that reducing Federal restrictions will enable States to target the funds better to their own needs. We believe that these considerations will persuade Congress that this proposal should be enacted.

SSA SPONSORED RESEARCH

Question: In what ways has SSA-sponsored research helped to reduce costs or improve efficiency in the AFDC and child support programs? Cite specific examples.

OCSE RESEARCH

Answer: The primary objective of child support enforcement research has been to document and evaluate alternate methods of State and local operations and management. After various techniques and methods were compared, recommendations for use of the most cost-effective procedures were presented to the States.

Comparative Analysis of Court System Procedures and Administrative Procedures for Establishing and Enforcing Child Support Obligations

This study was conducted by the University of Southern California, Center for Health Services Research. The study compared nine different jurisdictions which were categorized as either totally court oriented, administratively oriented or quasi-administrative in establishing and enforcing child support obligations. It found that administratively oriented systems had lower costs per case, collected more money per case, and processed cases in a shorter period of time. Since the report was issued, four States that were court oriented have adopted administrative procedures. Fifteen States are now administratively oriented and other State legislatures are reviewing their procedures.

Comprehensive Evaluation of Child Support Enforcement Program

This study, conducted by Maximus, Inc. began in September 1979 and will continue for three years. It is a comprehensive analysis of the program which has two principal goals: 1) to evaluate the impact of the program on welfare costs; 2) to identify methods of operation that are most effective and least costly. One of the specific suggestions which is currently being implemented in some States is the prioritization of the CSE caseload to achieve maximum cost-effectiveness. The report also recommends using mandatory wage assignment in lieu of more costly procedures. A number of States have enacted mandatory wage assignment statutes since this report was issued.

AFDC RESEARCH

Research and demonstration activities have been an integral part of AFDC program development and policy implementation. While R&D by definition is experimental and exploratory, SSA-sponsored research has resulted in efficient cost effective practices which States are successfully adapting to their own programs. The following projects are examples that demonstrate this.

Monthly Income Reporting Projects

Between 1975 and 1978, a monthly reporting system was designed and tested in Colorado. The Colorado pilot project resulted in 4 1/2 percent reduction in payment levels. In 1980, Massachusetts, Michigan and Illinois began similar projects. Evaluations of these projects have not yet been completed.

Based on these projects, Congress passed legislation last year requiring monthly reporting nationwide.

Administrative Improvement Strategies for State AFDC Managers

Completed in 1981 by the Wisconsin Department of Human Services, this project developed strategies for utilizing effective AFDC administrative practices and documented which factors enhanced or impeded transfer of such practices. One component was a National Demonstration Seminar to demonstrate the use of a computer training package and related handbook in determining eligibility for AFDC and related income maintenance programs. A second component was the provision of technical assistance to States interested in possibly replicating the demonstration technology and procedures. Underlying both components was an evaluation to determine what is required for States to adapt practices, technologies, and research findings. The evaluation identified such constraints as differing policies, organizational needs and computer capabilities and such facilitators as long-term staff sharing in achieving utilization by an "adopting" agency. The evaluation findings provide a basis for guidelines to utilization, planning, and implementation applicable to each jurisdictional level.

Michigan Voluntary Heating Fuel Project

Currently in its fourth year, this project has saved the State several million dollars by eliminating duplicate payments through vendor payments. The State expects larger savings each year. In addition to reducing duplicate payments for heating fuel, the project has eliminated administrative problems associated with bill collecting.

Integrated Quality Control

Integrated Quality Control (QC) is a technique which significantly reduces the resources required to perform QC review.

Integrated QC involves review of the same cases for different income maintenance programs, instead of a separate review of multiple cases. Prior to 1976 a methodology for integrated QC did not exist. Between 1976 and 1978 SSA sponsored projects in Colorado, Illinois, New York, Montana and Rhode Island and subsequently held a conference on integrated QC in 1978. These activities led to the development of an acceptable integrated QC methodology which is now used by 24 States.

SSA is sponsoring several projects to further refine this technique in Florida, Georgia, Maryland, South Carolina, Wisconsin and Wyoming. Wyoming estimated that integrated QC saved three person-days per month. Colorado estimated savings of $53,000 per year.

Error Prone Profiling

Error Prone Profiling (EPP) is a technique which reduces errors by identifying cases which are most likely to be in error. SSA pioneered this technique between 1974-1976 through research grants in West Virginia, New Hampshire, South Carolina and Texas, and errors were reduced 3-10 percent. A current grant to Florida will produce the software necessary for EPP to be used by minicomputers which the Department of Agriculture's Food and Nutrition Service is placing in each State. This software package will provide EPP capability for Food Stamps and Medicaid as well as AFDC, will allow the analysis of error types and costs, and could provide a national QC data base for reporting and analysis.

Research on EPP is continuing in New Hampshire. The State projects savings of $56,000 per month as a result of selective case review. South Carolina estimates savings of $300,000 - $400,000 per year. The technique is now being used in six States.

Comprehensiveness of AFDC Administration in Management

This contract identified problems impeding the accuracy and quality of AFDC administrative management. Projects were conducted in six local agencies--two in each of three States representing a range of administrative characteristics and costs for eligibility determination and case maintenance. Findings gave impetus to several major improvements in Federal AFDC management such as development and operation of a system of administrative standards and consolidation of procedures common to AFDC and other income maintenance programs, e.g., quality control (combined sampling) and avoidance of waste.

Electronic Funds Transfer

In 1978, an electronic funds transfer (EFT) program was tested in Cleveland, Ohio. AFDC benefits were transferred from the State directly into the individual savings account of the recipient. This resulted in a significant reduction in the incidence of lost or stolen checks, duplicate payments and fraud. Recipients showed a strong preference for EFT.

Similar projects are underway in California and Connecticut.

Evaluation of AFDC Quality Control Corrective Action

This study was conducted to answer questions about effectiveness of Federal and State measures to reduce errors in AFDC eligibility determination and payment amount. Such questions focused on the reasons for rising administrative costs and whether the savings from reduced AFDC payments justified the cost of corrective action. Findings indicate:

(1) that corrective action had only a minor role in increasing administrative cost and that these costs--$64 million against $140 million in cost avoidance or savings--were justified; and

(2) that a need exists for better management data especially on the dollar impact of error.

Telephone Fair Hearings

A project in New Mexico tested the cost-effectiveness of conducting fair hearings by telephone. Not only did the project reduce travel costs and save staff time, but the technique was well received by both lawyers and recipients. It is estimated that the costs of fair hearings could be reduced by as much as 25 percent if this technique was applied nationwide, resulting in annual Federal savings of $1.6 million.

Massachusetts AFDC Recoupment Project

A new system for the recoupment of erroneous AFDC payments was designed and implemented in Massachusetts. The State centralized responsibility for recoupment and enforcement activities and automated the accounts receivable systems.

In 1979, the year prior to development and implementation, total recoupment in the State amounted to about $420,000 or 1 percent of all erroneous payments. This year, the State is projecting total recoupment of about $10,000,000.

A number of States have expressed an interest in the Recoupment Project. The project may provide the basis for technical assistance and technology transfer to States which would meet the recoupment requirements of the 1981 Welfare Amendments.

In keeping with the Department's emphasis on research and demonstration projects with a high potential for future application, the Office of Family Assistance is currently undertaking or considering the following projects:

- Development of an Enhanced AFDC Quality Control Data Processing System--This aforementioned Florida project will encompass enhanced QC data processing systems for the Food Stamp and Medicaid programs, in addition to AFDC, based on Federal plans for integration of the QC forms and the national teleprocessing network. This approach utilizes the minicomputers furnished to the States by the Food and Nutrition Service, USDA, with Federal intervention through the nationwide network. As originally planned, the project will culminate with the software being made available for the network, including all supporting documentation, and a national workshop explaining the system to interested States.

- Analysis of Models of Strategies and Procedures for Implementing Community Work Experience Projects--Four to six Section 1115 grants will be awarded to States to administer and analyze models of strategies and procedures for implementing CWEP. These demonstrations will provide information on the legal, regulatory, organizational, administrative, and socio-economic issues encountered in implementing CWEP and what approach works best in various settings.

- Urban Error-Prone Profile Demonstration--The effectiveness of error-prone profile projects has not been definitively demonstrated to date in large urban areas. This project would allow States to demonstrate error prone profiles in heavily urban areas. The projects would assess the effectiveness of the system on reducing program costs and compare urban vs. rural differences.

- Analysis of Structured Job Search--Several programs of structured job search for AFDC clients are in existence across the nation and appear to be gaining in popularity as alternatives to traditional WIN activities. They usually involve training in how to find a job and extensive peer group support in looking for jobs. Available data suggest that these programs are extremely cost-effective. These programs would be examined and compared to determine ways of maximizing their cost-effectiveness in helping AFDC recipients find jobs and reduce their dependence on the program.

LOW INCOME ENERGY ASSISTANCE

Question: How many households were aided in the Low Income Energy Assistance Program in fiscal years 1980 and 1981 and what were the average payment levels?

Answer: The FY 1980 Supplemental Energy Allowance Program for the low-income population was authorized by Public Law 96-126 and consisted of three subprograms: direct energy assistance payments to SSI recipients by the Social Security Administration; formula grants to States by the Social Security Administration; the Energy Crisis Assistance Program administered by the Community Services Administration. A contract study performed for HHS indicated that the FY 1980 Energy Assistance program provided benefits to 9,690,000 households with an average benefit level of $151 per household. However, the number of households is overstated by some unknown extent due to duplication in counting.

The FY 1981 Low Income Energy Assistance Program (LIEAP) was authorized by the 1981 Continuing Resolutions (P.L. 96-369, P.L. 96-536 and P.L. 97-12) and permitted States to provide heating and cooling assistance to low-income households. The following data are based on preliminary reports pending the close-out of the FY 1981 program. The States, tribes and territories were required to report unduplicated cumulative counts of total households receiving heating assistance; however, HHS has not verified that the counts were unduplicated in the reports. Furthermore, States were not required to indicate which of the households receiving medically-necessary cooling assistance also received heating assistance.

The 50 States, the District of Columbia and 56 direct-grant Indian tribes reported that approximately 7.2 million households received LIEAP heating assistance at an estimated average benefit level of $225. Eighteen States and the District of Columbia made medically-necessary cooling assistance payments to approximately 370,000 households. The territories, with the exception of the Northern Mariana Islands, reported that approximately 32,000 households received LIEAP assistance.

Question: How many of those aided were elderly households?

Answer: In FY 1980 there were no reporting requirements for the number of elderly assisted. The Social Security Administration did, however, issue checks for energy assistance to all SSI households of which it is estimated that more than 50 percent are elderly.

In FY 1981 about 40 percent of the applicant households contained at least one elderly member. We are currently developing estimates for automatic payment households.

Question: What do you expext these figures to be in FY 1982?

Answer: States were not required in their FY 1982 Low Income Home Energy Assistance Program (LIHEAP) applications to provide estimates of how many households would be served. Therefore, we have no basis upon which to make such estimates. We will, however, be conducting a telephone survey of State programs which should provide some estimate of the number of households to be served. We will provide the Committee that information when it becomes available.

Question: What percentage of income does the typical low-income family pay for home energy? The typical middle-income family?

Answer: The following table shows statistics from the Residential Energy Consumption Survey: 1979-1980 Consumption and Expenditures on the percent of income spent for all residential fuels except gasoline.

1978 Family Income	Percent of Income
Less than $5,000	24.4
$5,000 to $9,999	8.8
$10,000 to $14,999	6.1
$15,000 to $19,999	4.7
$20,000 to $24,999	4.1

ADMINISTRATIVE COSTS

Question: What percentage of energy assistance funds have been used for State and local and Federal administrative costs?

Answer: States may use up to 10 percent of their allocation in each fiscal year for planning and administering the Low Income Home Energy Assistance Program. Any costs beyond the 10 percent must be taken from non-Federal funds. In the FY 1981 LIEAP, States were allowed to use Federal funds for administrative costs up to 7.5 percent of the cost of carrying out the program. The amount used for Federal administrative costs in FY 1981 was 0.2 percent of the total. This is projected to be about the same level in FY 1982.

Question: How does this compare to cash benefit programs?

Answer: It is difficult to compare the administrative cost burdens of the energy assistance program with those of cash benefit programs like AFDC because of varying administrative requirements. However for FY 1981, the costs of State and local administration and training represented 10.6 percent of the total Maintenance Assistance activity.

Where States choose to make automatic payments to categorically eligible households, the energy assistance program is similar to a cash assistance program. With regard to the comparison of administrative costs in programs based on automatic payments versus programs with application processes, a contractor study of the FY 1980 energy assistance program found that the automatic payment program was less expensive to administer than a vendor payment program. We will soon have data on the FY 1981 program comparing administrative costs of States making automatic payments versus States taking applications.

SSI-DISABLED CHILDREN

Question: In the SSI program, the number of blind and disabled children continues to rise from year to year. Is there any single factor that is causing the increase in this population?

Answer: The main reason for the increase in the number of blind and disabled children in the SSI program from year to year is the fact that few of these children ever leave the rolls once they become eligible for benefits. Unlike the adult SSI population which ceases to receive benefits upon death, return to work, or medical improvement, most disabled children have been disabled since birth and have little chance for medical improvement due to the severe nature of their disabilities.

SSI DEMONSTRATIONS

Question: In fiscal year 1983, the Department is requesting $2 million for SSI demonstration projects. What would these funds be used for?

Answer: The research office is developing plans in each of three areas. They will be presenting these plans to me for a final decision prior to their being undertaken. I am not in a position to tell you what the final design of the projects will be, but I can describe the plans that currently are under development in the research office.

The first project involves drug addicts and alcoholics--a group singled out by Congress in P.L. 96-265 for a demonstration study. Evidence suggests that current SSI recipients designated as alcoholics or drug addicts are predominately older, are in the advanced stages of addiction, have irreversible medical problems, and demonstrate little recovery or rehabilitation potential. The demonstration projects envisions providing SSI benefits and treatment to a group of alcoholics and addicts who are not yet at a stage where they would be eligible for SSI. Because it would be earlier in their addictive process, the group would be younger and have more rehabilitation potential than the current recipients. An experimental group will receive payments, treatment and monitoring as provided for under current law. A control group of the same people who are not eligible for SSI will receive neither payments nor treatment. Both groups will be observed for two years or more to determine if the rate of recovery and return to productive employment is sufficient to demonstrate that earlier treatment can prevent permanent disability in alcoholics and drug addicts, thereby reducing SSI program costs.

The second project is planned to demonstrate the efficacy of programs to rehabilitate retarded recipients through supported work. About 70,000 individuals yearly become SSI recipients based on the disability of mental retardation. This condition generally does not improve; and recipients, who typically join the rolls as children or young adults, can remain dependent on SSI for an entire lifetime at a benefit cost of well over $100,000 for a single recipient.

Supported work programs place trainees in real jobs with specially trained supervisors. They emphasize work habits such as punctuality and appropriate conduct as well as job skills.

We will contract with experienced organizations to conduct a supported work program for samples of recipients of various ages and severity of disability. We expect to learn what types of recipients can be brought to the level of self-support and independence and which types of training, some more costly than others, are effective. The demonstration would test whether a program of this type could be cost effective.

The third project discussed in the budget justification would evaluate whether it would be cost effective and appropriate for the SSI program to require more frequent reporting from selected SSI recipients. SSA may not have to resort to a demonstration project to study mandatory periodic reporting. SSA is currently planning a study using administrative records and is about to let a contract to study the efficacy of more frequent reporting from select categories of SSI recipients. The study would determine if it is possible to save program dollars in excess of administrative expenditures by mandating more frequent reporting as a condition of eligibility for check receipt. It would determine if SSA can identify in advance the category of cases which would fall under such a requirement and the preferred frequency of reporting for the various types of cases. Finally, it would measure the burden imposed on the client and the Agency.

After these efforts are completed, we will know whether we can make decisions on periodic reporting based on the data we have or whether we will need to conduct the demonstration project for additional information. Based on the anticipated timing of our study of administrative records, we now think the demonstration project, if needed, would not be conducted until fiscal year 1984.

Question: What would be the adverse effects of failing to appropriate these funds?

Answer: The authority to conduct demonstrations in the SSI program was contained in the 1980 Disability Amendments. These amendments require a final report on all demonstrations in mid-1985, and it appears that the authority to undertake new projects expires at that time. If we are unable to launch a particular demonstration in fiscal year 1983, it may not be possible for us to meet the deadlines that the Congress established in the 1980 amendments. Further, if we neglect to use the authority currently available to conduct these demonstrations, we will lose the opportunity to test possible ways of improving the SSI program and reducing program costs.

SYSTEMS IMPROVEMENT

Question: Mr. Commissioner, the Committee is pleased that you have recently released your new plan to upgrade the Social Security Administration's computer systems. Could you briefly describe what your plan involves?

Answer: The plan involves moving the Social Security data processing system from its current "survival" mode into a modern system which will provide all services which are required by law and necessary to serve the public.

Discussion of the Plan

The SSA Systems Modernization Plan has been structured into four programs. They are: Software Engineering; Data Base Integration; Data Communications Utility; and Capacity Upgrade. Three distinct levels of results are described for each program. These levels equate to the following critical time periods of this 5-year plan for modernization:

--Level 1 (First 18 Months) - Immediate actions are completed which provide the necessary improvements in ADP capability and capacity to enable SSA to survive its current ADP crisis.

--Level 2 (Second 18 Months) - Having avoided disaster, this period involves implementing those changes required to begin to move SSA into a modern data processing environment, paving the way for final transition to the state-of-the-art operation of a redesigned benefit payment system.

--Level 3 (Last 24 Months) - Final integration activities result in testing and certifying the redesigned system. This period brings together the completed increments of new applications software, an integrated data base, a communications utility, distributed processing and the final hardware configuration.

Software Engineering Program

The main thrust of the plan is the software engineering effort which is implemented through two major projects--Software Improvement and System Design and Development. The Software Improvement Project will provide upgraded performance for existing computer programs, increase maintainability, and prepare programs for use in system redesign. The System Design and Development Project will provide the requirements for system renewal and use portions of the improved system software to satisfy system requirements, where possible.

As part of software engineering, a top-down functional analysis of the SSA process will be conducted to provide the framework for the evolutionary redesign of the systems. This analysis builds the foundation for the modernization program, establishing the requirements for improvements to the existing software.

Data Base Integration Program

The Data Base Integration Program consists of two major projects--Data Administration and Data Management. Data Administration includes the standardization and validation of data elements and files prior to their use in the future design. Data Base Management includes those activities necessary for an orderly and controlled transition from sequential magnetic tape processing to on-line direct access processing.

Data Communications Utility Program

The purpose of this program is to re-engineer the SSA Data Acquisition and Response System (SSADARS) to improve service to field offices through increased reliability, flexibility and maintainability.

Capacity Upgrade Program

Hardware limitations at SSA not only restrain the capability to meet current production workloads, but also restrict efforts to upgrade software and redesign the system. The three preceding programs described planned activities to correct problems and make system improvements of a non-hardware nature, which are prerequisites for a modernized computing system.

This program addresses the capacity requirements. Its three major objectives are as follows:

1. To provide immediate increases in computing capacity to the current high priority programmatic workloads and to reduce today's processing backlogs.

2. To provide increases in capacity to meet or exceed all projected increases in workload demands for new services and changes in program requirements within the next 3 years.

3. To consolidate, convert and replace computing components and to apply new technological advances in hardware, software and data base management together with the expanded capacity needed to support a new modern integrated beneficiary system.

Question: How serious is the current situation in the SSA computer facilities?

Answer: The current situation in SSA's computer facilities is extremely serious. The computer operations have suffered a continuous degradation for almost a decade, and the crisis is now apparent in all aspects of SSA's ADP environment--software and operating systems, the computer equipment, the communications system, and the personnel who work on it.

SSA is highly dependent on computers to effectively administer its programs and is now only marginally capable of performing critical program functions such as issuing monthly checks to 36 million Social Security beneficiaries and 4 million SSI beneficiaries. Because of its serious ADP problems, the Agency sustains its operations with very costly manual processes and defers action on many critical projects that would benefit the public and result in substantial program and administrative savings. Further, millions of dollars are wasted in the administration of SSA's programs due to an antiquated computer system employing various levels of technology spanning more than two decades. As an example of this situation, implementation of the normal cost-of-living benefit increases last year required 20,000 hours of computer processing, day and night, over a period of four months. A system using today's technology should be capable of performing this task in a matter of a few days.

Question: How much of a backlog is there in the current system?

Answer: The computer backlog has reached about 120,000 hours of processing time. Because of this backlog SSA has been unable to carry out its earnings enforcement operation--a primary means of detecting overpayments--and to employ automated means to detect conditions indicating potential fraud.

CONTINUING DISABILITY INVESTIGATIONS

Question: How much money and how many man-years does SSA plan to spend on continuing disability investigations (CDI's) in FY 1983?

Answer: We estimate that we will spend about $244 million and 1,240 Federal work-years in conducting medical continuing disability investigations (CDI's) in FY 1983. This includes the costs for 152,000 regularly scheduled CDI's which are part of SSA's normal CDI program of diarying cases where recovery is expected, as well as for 654,000 additional CDI's to meet the requirements of the periodic review provisions of the 1980 Disability Amendments, which apply to the Social Security programs, and to carry out the Administration's decision to extend periodic review to the SSI program. Most of the cost of medical CDI's--about $214 million in FY 1983--is for work done by State Disability Determination Services.

Question. How much will be spent on regular DI beneficiaries? How much on SSI beneficiaries?

Answer: Of the total $244 million and 1,240 Federal work-years, $176 million and 1,160 work-years will be spent for the regular disability insurance program and $68 million and 80 work-years will be spent for the SSI program. This includes allocating between the DI and SSI programs a share of the money expended on CDI's for people who are entitled to both DI and SSI benefits concurrently.

Question: What should this investment in CDI's yield in savings?

Answer: The investment of administrative resources in medical CDI's is more than offset by projected benefit savings. The budget now before the Committee includes estimates of the benefit savings that will result from the additional CDI's to meet the requirements of the 1980 Disability Amendments and to extend periodic review to the SSI program. These estimates exclude the regular medical CDI diaries for cases where recovery is expected. In computing the administrative costs of the CDI program to be compared with anticipated benefit savings, we have included--in addition to the costs of the CDI's themselves which I provided in response to the previous question--the costs of the additional reconsiderations, hearings and appeals which will result from terminations from the rolls as a consequence of CDI reviews. The following table compares the administrative costs for the additional CDI's (including resulting appeals) proposed by SSA in its budget with the projected benefit savings to be achieved from investment of these additional administrative resources:

	($ in millions)	
	FY 1982 Estimate	FY 1983 Estimate
Administrative Costs........	$156	$272
Benefit Savings.............	372	730
Net Savings.............	$216	$458

The benefit savings include $2 million in FY 1982 and $30 million in FY 1983 for the SSI program.

BUDGET FOR LIMITATION ON ADMINISTRATIVE EXPENSES

Question: Mr. Commissioner, last year this Subcommittee recommended a fiscal year 1982 Limitation on Administrative Expenses budget of $3.053 billion. The Administration made a serious effort to reduce this to $2.946 billion, but after Congressional intervention, the final amount for administrative costs was set at $3.017 billion.

Now you are requesting an FY 1982 supplemental of $42.9 million which would put the program level above even the Subcommittee recommendation.

How do you explain this?

Answer: Our original plan for living with the Administration's FY 1982 budget reductions assumed that legislative changes would be submitted and approved to relieve SSA of certain administrative requirements and save $42.9 million. This did not take place. We now are requesting a supplemental to restore those funds.

The third Continuing Resolution for FY 1982 made available to SSA $3.017 billion for the Limitation on Administrative Expenses account. We are doing our best to live with this level of funding and we have taken further action to save money such as implementing additional procedural changes to reduce work-years, and cutting back in non-ADP equipment expenditures. Our current plan also calls for full use of the $70 million contingency reserve which is part of the $3.017 billion made available to us. However, without the

$42.9 million supplemental we will have to postpone some very important activities planned for FY 1982, which will produce savings in benefit payments--for example, stepping up debt collection efforts and carrying out the full program of investigating the continuing eligibility for benefits of those on the disability rolls.

Question: What are these supplemental funds required for?

Answer: The supplemental funds are required to restore the $42.9 million which we orginally expected to save through legislative changes to reduce or eliminate the following requirements in existing law:

--Preparation of personalized denial notices for disability applicants whose claims are denied ($20.7 million),

--Payment to claimants for the cost of medical evidence of record in support of their disability insurance claims ($7.4 million),

--Providing the free service to the legal community of deducting attorney fees from benefit payments made after successful appeals ($5.2 million), and

--Earmarking $24.6 million for SSA's construction activity in fiscal year 1982 ($9.6 million).

If the supplemental is not enacted, these activities, which are required by law, must be carried out. Instead, SSA will have to cut back on certain discretionary activities in the latter part of the fiscal year in order to operate within the present authorization.

Under this plan, backlogs will have to build; and work on initiatives to reduce program costs, such as continuing disability investigations and debt collection, will have to be deferred. Other possible areas which could be affected by reductions late in the year are automatic data processing purchases, and work on adjusting benefits for beneficiaries who have continued to work and as a result are entitled to higher monthly benefits.

ADMINISTRATIVE LAW JUDGES

Question: The Committee understands that there is a considerable backlog of cases awaiting hearings which administrative law judges must hear. How can SSA increase the output of its administrative law judges?

Answer: The Social Security Administration has developed a plan of initiatives to improve productivity in the hearing offices and increase the output of its administrative law judges (ALJ's). Our plans include the following:

--Increasing the level of support staff to ALJ's.

--Implementing more efficient organizational arrangements and workflows in the hearing offices.

--Upgrading the quality of word processing and recording equipment in the hearing offices.

--Establishing word processing centers in two regions to assist with heavy typing burdens in these regions.

--Considering establishing a corps of decision writers to be located in the Office of Hearing and Appeals headquarters to give additional support to the ALJ's.

--Improving and expanding training for both new and experienced ALJ's and their support staff.

The emphasis on training may result in a slightly lower production rate initially; but by 1983 we expect the combined impact of increased training and other management improvements to increase substantially the average production rate of ALJ's.

Question: How many administrative law judges does SSA presently have? How many cases must each hear annually?

Answer: As of March 6, 1982, SSA had 754 administrative law judges (ALJ's) on duty. The budget provides for 802 ALJ's on duty at the end of fiscal year 1982 and 800 at the end of fiscal year 1983.

We estimate that each ALJ will hear an average of 422 cases during 1982 and 479 cases during 1983. Based on these production rates, we expect to process 339,700 hearings in FY 1982 and 383,300 in FY 1983.

SSI PROPOSED LEGISLATION

Question: Provide a detailed breakdown of the proposed legislative changes in the Supplemental Security program.

Answer: The proposed legislative changes are as follows:

--That the first month's SSI benefit be prorated based upon the date of application or, if later, the date upon which the individual becomes eligible for SSI.

--The monthly SSI benefit guarantees will be rounded to the next lower dollar when cost-of-living increases are calculated.

--Provide that, for the purpose of determining whether a person is disabled, the medical impairment must be expected to be disabling for a continuous period of not less than 24 months.

--Change the definition of disability to base it on a preponderance of medical factors.

--Eliminate the $20 per month disregard for purposes of eligibility and benefit determination in cases of applications filed on or after January 1, 1983.

--Authorize SSA to recover overpayments made to an individual under any SSA-administered program, such as Social Security, Supplemental Security Income and Black Lung, by adjusting benefits payable to the individual under any other SSA-administered program.

--Provide for the coordination of SSI and OASDI cost-of-living benefit increases under retrospective budgeting.

AFDC LEGISLATIVE CHANGES

Question: The Administration is proposing a series of legislative changes in the Aid to Families With Dependent Children program. These are designed to save another $1 billion on top of what we cut last year. For example, one of your proposals is to count Low Income Energy Assistance as income, so that welfare payments will be reduced.

The Congressional Budget Office recently published a study that last year's package of tax and spending cuts will take a total of $4.5 billion away from the lowest income groups and give $15.9 billion to people with over $80,000 a year. At the household level, this means an average reduction of $240 a year for the lowest income groups, but an average increase of over $15,000 for each household over $80,000.

Summary Table 1. Net Change in Federal Individual Income Taxes and Federal Benefit Payments for Individuals by Household Income Calendar Year 1983 (in 1983 dollars)

		Household Income (in 1982 dollars)				
	All Households	Less than $10,000	$10,000-$20,000	$20,000-$40,000	$40,000-$80,000	$80,000 or more
Change in Total Federal Taxes and Benefits (in millions of dollars)						
Cash benefits	-11,950	-5,190	-2,960	-2,740	-990	-80
Taxes	82,130	2,340	9,290	28,720	25,780	16,000
Net	70,180	-2,850	6,330	25,980	24,790	15,920
In-kind benefits	-5,560	-1,680	-1,610	-1,430	-790	-50
Net including in-kind benefits	64,620	-4,530	4,720	24,550	24,000	15,870
Change in Average Federal Taxes and Benefits per Household (in dollars)						
Cash benefits	-140	-270	-140	-90	-70	-70
Taxes	940	120	440	950	1,830	15,250
Net	800	-150	300	860	1,760	15,180
In-kind benefits	-60	-90	-80	-50	-60	-50
Net including in-kind benefits	740	-240	220	810	1,700	15,130

		Household Income (in 1982 dollars)				
	All Households	Less than $10,000	$10,000- $20,000	$20,000- $40,000	$40,000- $80,000	$80,000 or more
Change in Federal Taxes and Benefits as a Percentage of Income						
Cash benefits	-0.5	-3.0	-0.6	-0.3	-0.2	--
Taxes	3.5	1.3	1.9	3.2	4.6	6.7
Net	3.0	-1.7	1.3	2.9	4.4	6.7

SOURCE: Congressional Budget Office

Question: How do you respond to the criticism that last year's reconciliation bill has already sharply cut AFDC benefit and eligibility levels, and that further cuts in welfare would be unfair? For example, a majo change enacted last year is the requirement that eligibility for AFDC be limited to 150 percent of the State's need standard. Yet, approximately half of the States have changed or anticipate raising their standard of need in order to restore benefits to many who would otherwise be cut off of AFDC. These changes have reduced anticipated savings from last year's reconciliation bill considerably.

Answer: The AFDC changes proposed last year and this year were developed not only to respond to the economic situation created by too much government spending but also to respond to problems with the AFDC program itself. For example, the earned income disregard policy under prior law permitted families to remain on AFDC for long periods of time with high earnings. Also, sources of income available to AFDC recipients were not considered. This Administration is committed to establishing the AFDC program as a well-run temporary assistance program which moves recipients into employment. The Administration's proposals are directed toward fulfilling that commitment. Those who are in need and who are not in a position to provide for themselves will continue to receive assistance. The Administration does not, in any way, view the AFDC changes as unfair, but rather as improvements and retargeting of the program back to its original purpose.

Question: Don't you feel that States will take similar action to help maintain benefit levels, and this will make your estimated savings of $1.1 billion hard, if not impossible, to achieve?

Answer: States have always had the flexibility to raise their need and payment standards, and it is difficult to determine when changes are in response to the legislation and when they would have occurred anyway. At this point, we have no evidence that States raising their standards in response to the legislation will significantly affect projected savings. As of October 1, 1981, the latest information available, States representing less than 15 percent of national expenditures adjusted their need standard disproportionately to their payment standard, thereby lessening the effect of the 150 percent of the need standard cap on income. On the other hand, the data on actual caseload reductions we have received so far suggest that the caseload impact of this cap has been greater than originally estimated.

WORKFARE

Question: What kind of work would AFDC recipients be given as part of compulsory workfare programs?

Answer: Participating AFDC recipients will be performing a variety of activities which serve a useful public purpose. Examples of the kind of work can be found in existing workfare programs. In Utah's Work Experience and Training (WEAT) program, participants provide services within agencies at all three levels of government. In Oklahoma's new Community Work Experience Program (CWEP), participants are being assigned to a broad range of jobs including day care aides, hospital and institutional aides, public works and maintenance workers and clerical workers. In West Virginia's new CWEP program, assignees are working as custodians and building maintenance aides, police helpers and ambulance assistants, library and park aides, meter maids, receptionists, clerical workers, and laborers. West Virginia has developed more than 3,300 slots with 350 sponsors. Many of these slots are Comprehensive Employment and Training Act (CETA) vacancies.

Question: Under the optional program, how many States have chosen to set up workfare?

Answer: Since most States have been focusing their attention on implementing the provisions mandated by the Omnibus Budget Reconciliation Act of 1981, they have had limited opportunity so far to set up workfare programs. Nevertheless, we expect at least 20 States to implement CWEP programs in the near future.

Three States (North Dakota, Oklahoma and West Virginia) implemented CWEP programs in January. Five States are implementing CWEP demonstration programs. We know of eight other States which intend to implement CWEP programs this year. Several other States have bills under consideration in their State legislatures to authorize CWEP or related work experience programs. Utah has been running a program similar to CWEP for more than 7 years. Finally, at least one State, Massachusetts, is implementing a work experience program as part of its WIN demonstration program.

Question: What evidence is there from actual workfare programs that they achieve their goal of getting recipients to work and reducing welfare costs? Can you give us some hard figures on this?

Answer: We have evidence from other workfare programs that mandatory work activities can reduce welfare caseloads and increase employment.

In Utah's WEAT program, 35 percent of those selected for participation through 1980 had their cases closed prior to being assigned. Nearly half of these cases were closed because the individual reported full-time employment. Of those who were actually assigned to projects, 34 percent obtained employment.

Results from the first seven pilot workfare projects run for food stamp recipients also show reductions in dependency. Preliminary data suggest that the majority of project participants left the project before actually participating in workfare, receiving an exemption, or being sanctioned for non-compliance. Those who were assigned to the workfare program were less apt to remain on assistance after 3 months than other recipients. About 28 percent became subject to sanctions for refusing to participate. Women who were subject to workfare were more apt to obtain employment than other female recipients. During the 3 months following work registration, they earned an average of $186 more than women in the comparison group.

INCOME VERIFICATION

Question: As you are surely aware, the General Accounting Office recently released a report which indicated that Federal procedures for the verification of income and asset data for beneficiaries of needs-based programs is inadequate, and may result in significant overpayments to beneficiaries. What response do you have to this GAO report?

Answer: SSA's responses to the two recommendations that impact on our programs are as follows:

GAO Recommendation - That steps should be taken to assure that OPM wage data on Federal employees is available for use in administering the programs.

SSA Comment - With respect to the Supplemental Security Income program, SSA has an enforcement process that makes use of data from IRS on the earnings of SSI recipients, including the wages of Federal employees who are SSI recipients. The use of OPM wage data in this process, or as a separate process, would be largely redundant and not cost effective.

SSA has an agreement with IRS that allows us to provide tax information such as wage data to States who administer the AFDC and food stamp programs.

GAO Recommendation - Require that, in administering needs-based programs, Federal, State and local agencies use available Federal and State wage data and SSA benefit data provided via BENDEX and SDX.

SSA Comment - We support the use of automated data matches to improve verification procedures. States who do not have the capability to perform such data matches are being assisted to improve their computer systems by recent legislation (section 406 of P.L. 96-265) which authorizes a 90 percent Federal match of the costs to develop and implement improved systems.

For the past few years, we have worked with the State welfare agencies regarding the use of Beneficiary and Earnings Data Exchange (BENDEX) and State Data Exchange (SDX) systems to verify client reported benefits and detect unreported benefits. Most recently we have effected changes in the BENDEX system to provide the State welfare agencies with additional data to allow verification of reported wages and Social Security numbers. States requesting automated systems development and operational funding under section 406 of P.L. 96-265 will be required to interface with and utilize data provided by the BENDEX system.

Question: What changes in law or regulations would you recommend to improve verification procedures?

Answer: The Administration has not as yet taken a position on the various GAO legislative recommendations. However, SSA has been working with the Internal Revenue Service to gain access to IRS information for purposes of administering the SSI program. IRS now has determined that SSA may have access to this information under current provisions of law. While the other GAO legislative recommendations would give Federal, State and local administrators of means-tested programs greater access to income data needed to administer those programs more efficiently, there are other factors which must also be considered in evaluating the recommendations. The concerns about possible governmental abuse of individual privacy that were the basis for the Tax Reform Act of 1976 and that historically have been the basis for prohibiting unwarranted access to Social Security records about individuals must be taken into account. From a practical standpoint, the ability of the Social Security Administration to operate major new systems for data exchange is severely constrained by the current precarious state of our automatic data processing systems. Finally, we must be concerned about any proposals which expand the mandatory use of Social Security numbers, because of the dangers associated with increasing the possibility of its use as a universal identifier.

ERROR RATES

Question: Are you able to make a commitment to achieve a zero percent error rate in the Federally-administered disability insurance or SSI programs by the end of fiscal year 1986?

Answer: No, I cannot make a commitment to achieve a zero percent error rate in the disability insurance or SSI programs by the end of fiscal year 1986. However, we are working very hard to improve payment accuracy in these programs, particularly as it relates to errors in determining and assessing continuing disability. Our programs of periodic continuing disability investigations for disability insurance and SSI cases and pre-effectuation review for disability insurance cases are aimed at preventing and detecting these disability errors. Further, in the SSI program we are continuing efforts to reduce nondisability errors through emphasis on hidden assets verification supported by a planned automated SSA-IRS data file match--or"interface"--to identify undisclosed bank accounts.

In the SSI program SSA has reduced the payment error rate for nondisability factors from 11.5 percent during fiscal year 1975 to approximately 5 percent over the past several reporting periods. We hope to reduce this error rate to 4.5 percent by the end of fiscal year 1983. Also, I want to point out that SSA has achieved a very low payment error rate of .28 percent in the old-age and survivors insurance program, during the latest sampling period.

We can't guarantee that SSA will achieve a zero percent error rate in the Federal programs it administers any more than we can guarantee that the States can achieve a zero percent error rate in the State-administered AFDC programs. However, SSA is fiscally responsible for Social Security and Federal SSI payments and pays the full cost of any errors the Agency makes in administering them. We believe the States should do the same with respect to the AFDC program--that is, bear the full financial responsibility for errors they make in its administration. For this reason the President's budget proposes to phase out by 1986 Federal matching for all AFDC benefit payments made in error by the States.

PERFORMANCE STANDARDS FOR STATES

Question: The Labor-HHS Subcommittee has expressed considerable concern about differing levels of performance among States in administering the AFDC program. In particular, the Subcommittee is concerned about the wide variance in the cost-per-case. What plans does SSA have to issue performance standards for the States?

Answer: Our current proposal is to consolidate administrative expenditures for AFDC, Medicaid, and Food Stamps in one grant and to cap these expenditures at 95 percent of the 1982 level. This cap would be in lieu of setting performance standards for administrative cost per case.

In the past, SSA has not issued performance standards because of administrative cost data deficiencies. A recent GAO report, HHS Moves to Improve Accuracy of AFDC Administrative Costs Allocation: Increased Oversight Needed, May 18, 1981, observed that the varying methods of cost allocation among welfare programs have precluded HHS from making meaningful comparison of administrative cost expenditures among States. A major activity designed to rectify this problem is the development of a cost allocation guide, the aim of which is to establish uniform cost principles and procedures which would produce more uniform, accurate, and comparable data.

Because of the lack of comparability of AFDC administrative cost data among States, the data have not been adequate as a basis for establishing standards. In spite of the inadequacy and the unreliability of the cost data, we have tried in the past to focus attention on the variances in administrative costs among the States in two performance profile reports (issued in 1980 and 1981 covering the years 1977-1978 and 1978-1979). A third report for the year 1979-1980, will be issued in the summer of 1982.

Question: Has the Department considered issuing reasonable cost standards of performance, and making States adhere to them?

Answer: We have done considerable work on developing unit cost standards and have concluded that the noncomparability of data precludes our issuing, at this time, standards to which States must adhere. However, we will be setting forth desirable levels of performance in our next report to be issued this summer.

Question: Under the proposal for a Welfare Administration Block Grant, isn't it true that the reduced grant for State administration of the AFDC program will hurt well-managed and inefficient States equally? Do you believe this is fair?

Answer: On the contrary, we are recognizing that much of the variation in levels of administrative cost per case is based on demographic and economic conditions over which States have no control. There is more equity in an across-the-board reduction which recognizes the real world differences among States than in varying the percent reduction based on an absolute standard that ignores these differences.

Question: Are you looking at criteria for these performance standards that measure quality of performance (e.g., reduced error rates) as well as costs?

Answer: Yes. Our current performance system does measure such quality of service activities as application processing time, timeliness of adverse action notice, and timeliness of hearing decisions. However at this time, we are unable to establish standard levels of performance because of the noncomparability of data. It is for this reason that we think the best approach is to cap administrative costs.

Interestingly enough, we have found no direct correlation between error rates and unit costs. Between FY 1979 and FY 1980:

- 10 States and the District of Columbia decreased both administrative cost per case and erroneous expenditures per case.
- 12 States increased both administrative cost per case and erroneous expenditures per case.
- 8 States decreased administrative cost per case and increased erroneous expenditures.
- 20 States increased administrative cost per case while decreasing erroneous expenditures.

AFDC ESTIMATES

Question: How are estimates for AFDC made?

Answer: AFDC cost estimates are derived from two principal variables--AFDC families and average benefits--taking into account the effects of savings from legislative proposals and administrative improvements. These estimates reflect basic assumptions with respect to the state of the economy, demographic trends affecting family formation and composition, proposed or enacted Federal legislation, and anticipated State program and policy actions. Variations in each of these factors can exert a significant impact on the number of AFDC families receiving benefits or on the average benefit which such families are likely to receive.

REVISION TO INITIAL ESTIMATES

Question: What assurance can the Committee have that a similarly inaccurate estimate for fiscal 1983 has not been submitted?

Answer: Although our budget request shows that we are planning to borrow more than $929 million from FY 1983 to fund the anticipated FY 1982 shortfall, we are not trying to hide the true costs of the AFDC program. Our estimates are based on the best data available on the many factors which affect the AFDC program, such as economic conditions, unemployment, implementation dates of program changes, and State error rates. About half of the shortfall for FY 1982 is a result of changes in economic conditions since the original estimates were made. Most of the balance of the shortfall occurred because the provisions of the Omnibus Budget Reconciliation Act of 1981 were not implemented by the States as quickly as anticipated in the budget because of legal and regulatory delays.

The AFDC program estimates for FY 1983 were prepared consistent with the economic and policy assumptions underlying the President's budget. These assumptions anticipate that the economy will be recovering from the current recession, that continued progress will be achieved by the States in reducing payment errors and increasing administrative efficiency, and that both the Congress and the State and local governments will actively support and fully implement the provisions of P.L. 97-35--the Omnibus Budget Reconciliation Act of 1981--and the legislation proposed in the FY 1983 budget. The AFDC budget estimates for FY 1983 are in accord with those expectations.

Question: What steps is SSA taking to improve the accuracy of its Assistance Payments budget estimates?

Answer: Budget estimating invariably entails a degree of uncertainty. To minimize estimating errors, SSA will continue to pursue and promote research efforts to develop the improved forecasting methods and analytical techniques needed to evaluate and anticipate program trends.

CHILD SUPPORT INCENTIVE PAYMENTS

Question: There has been some concern that incentive payments to States under the Child Support Enforcement program may be too generous. What plans does the Administration have to review the current incentive payments system?

Answer: We have been reviewing the entire funding structure of the Child Support Enforcement program in an effort to strengthen it. We hope to be sending to you very shortly our legislative proposal, the effect of which has been included in this budget submission. Our proposal changes the funding structure to link funding more directly to program performance, and is intended to encourage States to both increase collections and operate more cost-effective programs.

Question: Under the present incentive payments system, many States make a net profit on the CSE program. What use do States make of the "profit" from this program? Is there any limitation on the use of funds?

Answer: There are no restrictions on the use of the incentives or the States' share of the collections. States may use these funds for whatever purpose they choose, including purposes other than child support enforcement.

Question: For the record, provide a list of all the States' administrative payments for CSE, and the net recovery they make, broken out by collections and incentive payments.

Answer: We would be happy to provide the table.

CHILD SUPPORT ENFORCEMENT DATA ON STATE SHARES 1/

1981

	State Share Expenditures	State Share Collections	Incentives Payments	Net Recovery*
Alabama	1,409,224	1,427,682	627,964	646,422
Alaska	626,459	372,697	113,004	-140,758
Arizona	693,433	743,399	147,298	197,264
Arkansas	852,609	697,349	384,898	229,638
California	24,014,918	50,267,285	9,296,128	35,548,495
Colorado	1,422,321	1,944,514	754,576	1,276,769
Connecticut	1,937,056	7,820,583	2,325,320	8,208,847
Delaware	628,122	1,000,749	300,059	672,686
Dist. of Col.	813,687	564,018	169,328	-80,341
Florida	2,684,780	4,965,124	2,080,183	4,360,527
Georgia	1,198,375	2,444,795	1,077,952	2,324,372
Guam	40,373	34,141	1,816	-4,416
Hawaii	495,370	1,563,546	497,160	1,565,336
Idaho	365,904	890,080	428,333	952,509
Illinois	3,358,036	6,026,941	1,936,064	4,604,969
Indiana	1,503,419	3,804,430	1,502,402	3,803,413
Iowa	1,453,397	6,586,129	2,105,711	7,238,443
Kansas	962,449	2,386,875	769,527	2,193,953
Kentucky	1,502,970	1,376,962	665,943	539,935
Louisiana	2,389,651	2,151,582	1,180,540	942,471
Maine	448,076	1,422,640	699,036	1,673,600
Maryland	3,196,722	7,513,335	2,131,270	6,447,883
Massachusetts	3,292,438	18,452,586	5,596,552	20,756,700
Michigan	7,582,602	43,652,022	11,550,309	47,619,729
Minnesota	3,203,606	8,918,464	2,736,984	8,451,842
Mississippi	494,017	139,612	57,361	-297,044
Missouri	1,842,287	2,467,367	887,964	1,513,044
Montana	280,355	366,637	152,652	238,934
Nebraska	593,480	1,225,997	418,668	1,051,185
Nevada	663,454	420,963	125,166	-117,325
New Hampshire	255,794	837,620	343,211	925,037
New Jersey	6,864,455	15,602,430	4,680,845	13,418,820
New Mexico	549,496	590,492	282,171	323,167
New York	15,888,810	23,877,718	7,163,338	15,152,246
North Carolina	2,172,234	3,959,045	1,724,424	3,511,235
North Dakota	255,897	566,572	219,237	529,912
Ohio	4,591,216	13,698,029	4,574,168	13,680,981
Oklahoma	1,229,065	810,074	326,403	-92,588
Oregon	2,876,053	5,458,964	1,845,427	4,428,338
Pennsylvania	7,511,975	16,619,160	5,399,439	14,506,624
Puerto Rico	310,438	126,662	73,146	-110,630
Rhode Island	397,476	1,511,330	504,626	1,618,480
South Carolina	452,249	898,952	380,964	827,667
South Dakota	256,595	372,412	117,925	233,742
Tennessee	1,175,403	1,124,897	568,285	517,779
Texas	3,653,132	2,686,968	1,113,979	147,815
Utah	1,245,461	2,547,753	1,238,314	2,540,606
Vermont	225,514	610,616	288,891	673,993
Virgin Islands	76,460	38,654	22,517	-15,289
Virginia	1,776,911	3,840,035	1,129,578	3,192,702
Washington	2,942,559	9,534,508	2,816,935	9,408,884
West Virginia	602,949	710,515	388,818	496,384
Wisconsin	2,846,128	13,832,299	4,944,612	15,930,783
Wyoming	69,411	255,424	68,886	254,899
Nationwide				
Totals	128,175,271	301,759,633	90,936,307	264,520,669

* State share of collections, plus incentive payments, minus State share of expenditures

1/ The data reflect the latest actuals received from the States as of March 15, 1982.

MANDATORY WORK PROGRAMS

Question: Will you provide the States with any funds to run these mandatory Community Work Experience Programs? I know you are planning further cutbacks in training programs under the Labor Department. Will the regular AFDC match rate be available for training, placement and administrative costs for mandatory work programs? How much do you expect them to cost, and how many people will be put to work?

Answer: States may use IV-A administrative funds to run their CWEP programs. These expenditures are matched at the regular 50/50 rate.

There are certain restrictions on the availability of matching funds for the CWEP program. AFDC money cannot be used to match participant expenses in excess of $25 per month; this figure was set as a reasonable limit based upon the experience of the Utah WEAT program. Costs of onsite supervision of participants, capital expenditures, and making or acquiring materials or equipment also cannot be matched. We believe it is reasonable for the projects receiving assignees to cover these costs since they do not provide any wages or reimbursement to participants. Finally, we do not cover costs associated with the use of facilities of the State public employment offices because Federal funds support those facilities.

We expect program savings from caseload reductions and administrative savings to offset the costs of operating the mandatory work programs.

We do not know how many people will be put to work in CWEP projects because unemployed parents are the only recipients who must be referred. Otherwise, States have great flexibility in deciding who should participate and what areas of the State should be included. Our savings estimates for mandatory CWEP are based on an assumption that about 440,000 people will participate in FY 1983.

COMBINED WELFARE ADMINISTRATION BLOCK GRANT

Question: What savings do you believe will accrue as a result of consolidating payments for State administration of welfare programs?

Answer: The consolidation of these three programs will save the Federal Government $302 million in fiscal year 1983 through elimination of duplicate staff effort for each of the programs, excess personnel and other factors. The estimated savings to the Federal Government over a 5-year period for these three programs is as follows:

($ in Millions)

	FY 83	FY 84	FY 85	FY 86	FY 87
AFDC................	$-41	$-89	$-136	$-181	$-223
Medicaid............	-218	-284	-393	-454	-528
Food Stamps.........	-43	-61	-84	-104	-124
Total..........	$-302	$-434	$-613	$-739	$-875

Question: Since eligibility for these three programs varies, how can a consolidated administrative grant improve management for these programs?

Answer: Even though eligibility for these three programs varies many of their administrative costs are the same. Under current law, these administrative costs are allocated and reported separately for each program according to a complex set of Federal requirements.

Eliminating the current practice of matching State and local costs on an open-ended basis will return control of administrative costs to the States, reduce accounting system and administrative effort required to allocate costs and provide a strong incentive for States to increase administrative efficiency and improve program operations.

Question: What has been the effect of the recently enacted law which limited eligibility for Supplemental Security Income and Medicaid for individuals who dispose of assets in order to make themselves eligible for these programs?

Answer: The enactment of Section 5 of P. L. 96-611 for the transfer of assets is projected to save up to $40 million FY 1982 and $60 million in FY 1983. These savings are assumed to have already been factored into the November 1981 State Estimates since the effective date for the Medicaid program was July 1, 1981. However, final regulations governing these provisions have not been published to date.

REFUGEE EDUCATION

Question: In fiscal 1982, $5.7 million was approved for Cuban/Haitian Entrant Education, and $19.7 million for Refugee Education. How large a grant per child will this appropriation permit?

Answer: The Education Department has advised us that the $5.7 million appropriation for fiscal 1982 for Cuban/Haitian Entrant Education will provide a $425 grant per eligible child and that the $19.7 million appropriation for fiscal 1982 for Refugee Education will provide a $320 grant per eligible child.

Question: When will these funds be obligated?

Answer: ORR proposes to transfer these funds to the Department of Education during the fourth quarter of FY 1982. The principal reason for waiting until that time is that these funds are intended to aid local districts for the 1982-1983 school year which begins in September, 1982. The funds for 1981-82 school year were given to the Department of Education in early FY 1982. These funds came from the FY 1981 appropriations for these activities.

Question: What are the roles of the Department of Health and Human Services and the Department of Education in the administration of these funds?

Answer: In July 1980, former Secretaries Harris (HHS) and Hufstedler (Department of Education) signed an interagency agreement for the provision of educational assistance for refugee children. This agreement also applies to the provision of educational assistance to Cuban and Haitian entrant children. According to this agreement, HHS assigned to Education the administration of elementary and secondary education education programs authorized by Section 412(d)(1) of the Immigration and Nationality Act (as amended by the Refugee Act of 1980) as well as assigned programs and projects for refugee children and entrant children. HHS transfers to Education funds for the Cuban/Haitian Entrant and Refugee Education Programs.

DEPENDENCY RATES

Question: What is the most current rate of welfare dependency for Southeast Asian refugees?

Answer: The most current figure for refugee welfare dependency is 67%. This figure was derived from a survey that ORR conducted in September, 1981, of the nine States most heavily affected by refugees. The figure reflects only those refugees who have been in the U.S. for 36 months or less.

Question: What is that rate for Cuban and Haitian entrants?

Answer: The overwhelming majority of the entrants reside in the State of Florida. As of January, 1982, the State reported about 40,000 entrants receiving cash assistance. The estimated Cuban and

Haitian Entrant population in Florida in January was about 125,000. This would yield an estimated dependency rate of about 32%. ORR is attempting to secure similar data from other entrant impacted States, but believes that the dependency rates in those other areas are not significantly different from Florida's.

Question: What long-and short-range steps can be taken to reduce this rate?

Answer: Several steps have been taken to reduce the dependency rate. First, ORR has issued a new policy to reduce the period of eligibility for refugee cash and medical assistance from thirty-six to eighteen months. It is anticipated that this policy change will lower the number of refugees who elect to defer seeking employment in favor of protracted training program. ORR is also finalizing State plan guidelines which will require the States to prepare social services funding plans which demonstrate the application of social service funds to the reduction of welfare dependency. Specifically, the States will need to give priority to the provision of employment services and English language training. State plans which do not meet these criteria will be returned for modification. ORR will also increase its efforts to assure that the States are effectively applying sanctions prescribed for refugees who refuse appropriate offers of employment. Finally, ORR is increasing its technical assistance to States to reduce the dependency rates. ORR is currently compiling descriptions of best practices of employment projects, which will direct States towards projects with potential for increasing refugee employment. ORR is also putting together technical assistance packages regarding English as a Second Language (ESL) for all Regional Offices to use in helping the States to strengthen the provision of ESL services to refugees.

VOLUNTARY AGENCY PROGRAMS

Question: The budget estimates an increase in funding for the voluntary agency program. Grants under this program serve primarily Soviet and East European refugees, by providing a grant of up to $1,000 per refugee for essentially all resettlement costs. The budget rises from $8,460,000 in FY '82 to $11 million in FY '83. Based on whatassumptions does the budget for this program increase?

Answer: The FY 1982 proposed admissions level for Soviet Jewish refugees, the principal group of refugees covered under this activity, is 9,000. Therefore, the original budget request is for $9,000,000. Under the provisions of the third Continuing Resolution, the budget level was reduced by 4%, to $8,460,000. The FY 1983 budget request of $11,000,000 is based on an estimated 11,000 Soviet Jewish refugees to be admitted into the country in 1983.

Question: Given the success of the resettlement effort under this program, has any thought been given to trying to duplicate this kind of voluntary agency resettlement program with Southeast Asian refugees or Cuban/Haitian Entrants?

Answer: With respect to the refugee program, we would be willing to receive applications from the voluntary agencies on behalf of Southeast Asian or other refugee groups not currently covered by the existing matching grants, within the limits of funds available for this purpose. For Cuban or Haitian entrants, the Administration's policy is one of prevention of new arrivals and detention of any persons who may arrive illegally; therefore, no major new resettlement program is anticipated.

A principal factor in the matching grant program is that the voluntary resettlement agencies are required to match the Federal grants on a dollar-for-dollar basis. We have not received any request from the voluntary agencies for a major expansion of the program or indication that they would find it feasible to match Federal funding for major groups of refugees beyond their current participation.

TARGETED ASSISTANCE

Question: In fiscal 1983, the Department is requesting targeted assistance for States with large numbers of refugees. How will these funds be allocated?

Answer: We would expect to follow a competitive grants application process similar to that which has been established for targeted assistance for Cuban and Haitian entrants in FY 1982. Consideration would be given to documented impact resulting from such factors as concentrations of refugees. Priority in the use of funds would be placed on efforts intended to lead to self-sufficiency.

Question: Will the States have complete flexibility in the use of these funds, or will there be restrictions on their use?

Answer: States will have a large degree of flexibility, but not complete flexibility since the funds must be used for purposes authorized under the Refugee Act. We plan to permit the use of these funds for any service permissible under section 412(c) of the Immigration and Nationality Act, as amended by the Refugee Act of 1980 -- the same as for the entrant targeted assistance funds in FY 1982.

Question: How was this budget derived: why not more money, or less?

Answer: The program of targeted assistance was begun to help aid those areas that are or will be impacted by large numbers of refugees and/or entrants. Based on a review of the situation and personal on-site visits to such impacted areas by ORR, HHS and other Administration officials, it is felt that funding targeted assistance at a level of $20 million would be sufficient to meet the needs of those areas.

REFUGEE SOCIAL SERVICES

Question: It is the Committee's understanding that the budget for refugee social services is formulated principally based on the number of new arrivals. Yet despite an increasing dependency rate for refugees, the amount budgeted for refugee social services continues to shrink: $93.6 million in fiscal 1981; $67.5 million in fiscal 1982; and a request of $59.2 million in fiscal 1983. How is the budget for refugee social services formulated?

Answer: The annual refugee social services budget request is principally based on the estimated number of admissions in the budget year. However, there is one slight adjustment to account for time necessary to be settled in the community before accessing social services programs. Therefore, the budget is based on the estimated number of refugee admissions in the quarter prior to the start of the budget year, plus the total estimated refugee admissions for the first three quarters of the budget year. This total population is then used to formulate the social services budget, which really consists of two parts: the request for vocational training programs and the amount for English as a Second Language (ESL) programs.

The vocational training component is developed as the product of the number of refugee arrivals and an estimated unit cost per person. The unit cost is based on historical data which has been adjusted for inflation and to account for the fact some refugee arrivals will not need or use vocational training (e.g., the refugee children).

For the ESL component, the total refugee arrivals figure is reduced to contain only the estimated adult population since the children would learn English at local schools. This adult population is then further reduced to arrive at an estimated adult population that will actually access ESL since not all refugee adults will need ESL, due to their age, inability to reach ESL classes or family situations. This population is then separated into estimated adults requiring short term and/or long term ESL. When the final population for each part is derived, a unit cost (based on historical data and adjusted for inflation) is applied to come up with the short-term and long-term ESL budget(s).

The sum of the vocational training and short-term and long-term ESL budget then is the annual refugee social services budget request.

Question: How does the Office of Refugee Resettlement target social services money to areas where it is most needed?

Answer: The Office of Refugee Resettlement (ORR) does not target social service funds on a geographical basis or on the basis of a needs analysis of refugee groups. ORR allocates social service funds through a formula, the objective of which is an equitable distribution of funds among the States based on refugee population.

ORR works with States to target social service funds on those services that contribute most directly to refugee achievement of economic self-sufficiency: employment services and English language training. State plans for the allocation of social service funds are reviewed by ORR to assure that they conform to the standard of refugee self-sufficiency. Targeting on a geographical basis or needs basis is done at the State level and should be reflected in the State plan which ORR receives.

CUBAN/HAITIAN DOMESTIC ASSISTANCE

Question: The fiscal 1983 budget estimate for Cuban/Haitian Entrant Domestic Assistance is $17.3 million, down from $84.4 million in fiscal 1982. On which revised assumptions is this budget request based?

Answer: The principal reasons for the decrease in the Entrant Domestic Assistance budget request from FY 1982 to FY 1983 are:

- A projected decline in the entrant dependency rate (for FY 1982, a rate of 33% was used; the FY 1983 budget used a 25% rate);
- Continuation of the 36-month limitation provision of the Refugee Act. The vast majority of entrants will attain their 36th month in the U.S. beginning in April, 1983; and
- A full year's impact of the new refugee/entrant cash assistance policy. That policy terminates non-AFDC recipients who have been in this country more than 18 months and do not live and/or qualify for a State or local General Assistance (GA) program. The overwhelming percentage of entrants currently on assistance receive non-AFDC aid and will have been in the country more than 18 months for all of FY 1983. Moreover, they reside in Florida, which does not have a GA program.

Question: What is the welfare dependency rate of Cuban/Haitian Entrants, and how does this compare to the estimate on which your FY 1982 budget was based?

Answer: The FY 1982 entrant budget assumed a 33% dependency rate for all eligible entrants. As of January, 1982, the State of Florida reported about 40,000 entrants receiving assistance. The State had an estimated 125,000 entrants, so that the dependency rate for entrants in Florida is about 32%. ORR is attempting to secure data for entrant assistance for other States, but does not expect any major differences from the experience of Florida.

Question: What are estimated expenditures for Cuban/Haitian cash and medical assistance for FY 1982?

Answer: With an April 1, 1982 implementation date for the new refugee/entrant cash and medical assistance policy, ORR estimates the FY 1982 entrant cash and medical assistance and related administration costs to be about $79 million.

Question: What actions are proposed to increase the employability of entrants and to improve their English language capability in light of the proposal to terminate benefits to these groups?

Answer: Termination of benefits to entrants who are not categorically eligible for AFDC benefits does not mean a termination of social services for this population. The State of Florida, where most entrants are located, has received $18 million in social service funds for fiscal year 1981 and would expect to receive another $8-9 million for the current fiscal year. Moreover, other States with substantial entrant populations have social service funds which can support English as a Second Language (ESL) and employment projects to help entrants move toward self-sufficiency.

ORR has recently published a notice of a targeted assistance program for $35 million, which is available to States having large entrant populations. This targeted assistance covers a range of services to entrants, and States receiving these funds would be able to target some portion of them to ESL and job services. Such funds can and should be used to deal with terminated entrant cash assistance cases. In short, from both social service allocations for FY 1982 and the targeted assistance program, there are sufficient funds available for States to address the service needs of the entrant population. States must, of course, design and focus projects toward the needs of this population.

NEW REFUGEE REGULATIONS

Question: Federal refugee policy helps both to advance American foreign policy aims and to further a good humanitarian purpose. Yet, Federal foreign policy should not be made at the expense of the States and counties which accept refugees, don't you agree?

Answer: We would agree.

Question: Do you at the Office of Refugee Resettlement believe that through the proposed regulations the Federal government is meeting its commitment to the States and localities which have accepted refugees?

Answer: Yes, the regulation is in accordance with the requirements of the Refugee Act. While the eligibility of refugees is changed after a refugee's first 18 months in the United States to make refugee eligibility for aid the same as the eligibility of our citizens, the policy would continue to reimburse States for those cash and medical assistance costs which they are required to incur under their existing AFDC, Medicaid, SSI, and GA programs.

Question: How do you respond to the charge that the Federal government's actions do not match its rhetoric?

Answer: We have specifically identified our view of the need for a policy change, have consulted with States and other interested parties on various options for change since the summer of 1980, have revised earlier proposals based on those consultations, and have explicitly set forth the new policy and the reasons for it. There is simply no basis in fact for the charge that the rhetoric and actions do not match.

Question: The Department has proposed regulations which significantly reduce the amount of time during which the Federal government will reimburse States for the cost of cash and medical assistance to refugees and entrants. What is the rationale for these new regulations?

Answer: The new regulations revise the eligibility of certain refugees and entrants for assistance but they do not reduce the time during which the Federal government will reimburse States for the cost of cash and medical assistance to refugees and entrants. Reimbursement will continue to be provided for 36 months for those costs which States are required to incur under their existing cash and medical assistance programs.

The need for revised assistance policies results from the very high dependency rates found last year -- 67% among those refugees who have been in the U.S. less than 3 years -- and from the widely reported conception on the part of refugees that there has been an entitlement to 36 months of assistance rather than a need to accept employment. The new regulations will: Continue to provide special eligibility during a refugee's most critical first 18 months in the U.S.; achieve equitability after that 18 months between aid available to refugees and that available to U.S. citizens in similar circumstances; encourage earlier employment among refugees; and constrain Federal costs while continuing to reimburse States for costs which they incur on behalf of refugees and entrants under their existing AFDC, Medicaid, SSI and GA programs.

Question: How do you respond to the criticism that the Federal government is reneging on its responsibility for a commitment to States for the costs of resettling refugees and entrants, who are in this country solely as a result of Federal policy?

Answer: We believe that by providing a policy which continues to offer reimbursement for cash and medical assistance program costs during a refugee's first 36 months, we are meeting the Federal commitment. Options were considered which would have reduced the period of reimbursement, but we preferred a policy which would continue funding for a 36-month period while limiting the special eligibility of a refugee to 18 months.

REFUGEE ADMISSIONS AND PLACEMENT

Question: The committee supports the intent of the Federal immigration programs, but feels that there must be a limit on the number of refugees permitted to enter this country. This is particularly so at a time when the Federal government appears to be somewhat reluctant to pay for the full cost of resettlement. How many refugees do you anticipate will actually arrive in the United States in FY 1982, and what are the projected FY 1983 arrivals on which your budget is based?

Answer: The President has announced that for FY 1982, the proposed refugee admissions level will be 140,000, including 100,000 Southeast Asians. There will be consultations held with the Congress in the near future to assess the refugee situation at midyear FY 1982. Through the first several months of FY 1982, actual Southeast Asian admissions are below the projected average monthly arrival amount. However, it is not certain if future arrival levels will continue at this lower rate. ORR does not make the decision on refugee arrivals; this is a Department of State responsibility.

The present FY 1983 refugee assistance budget request is based on an estimate of about 114,500 refugee admissions. This estimate includes 103,500 refugees to be assisted through the State Administered Program and 11,000 Soviet Jewish refugees who will be served by the Voluntary Agency Program.

Question: What steps are being taken by the Office of Refugee Resettlement to disperse new refugees more equitably among States and to prevent migration to a few heavily impacted areas?

Answers: In collaboration with the national voluntary refugee resettlement agencies and the Department of State, we have begun the development of an overall refugee placement policy which will be directed specifically at the objectives you have indicated -- to assure a more equitable geographic distribution in refugee resettlement and to avoid additional impacts on areas which already have high concentrations of refugees.

REFUGEE EDUCATION ASSISTANCE

Question: If the Federal government recognizes a responsibility to help States pay for cash and medical assistance for 18 months, why does it not feel a responsibility to pay for refugee education?

Answer: Since the initial flow of Southeast Asian refugees into the United States in 1975, the Federal government has undertaken to provide funds to help school systems build their capability for meeting needs resulting from new refugee flows and to offset some of the costs of providing supplementary services -- primarily English language traning. We have not proposed to try to meet the cost of refugee education, and, especially in a time of major Federal fiscal constraints, we believe it is best to concentrate available funds on enabling adult refugees to become employed and self-supporting members of the communities they are living in. To the extent that this can be achieved, they will be taxpayers on the same basis as other residents and thereby helping to support school costs.

REFUGEE/ENTRANT MEDICAL CARE

Question: We all know that medical care is one of the heaviest burdens borne by local governments where we have a lot of refugees. In response to Senator Hatfield's question at the Judiciary Committee hearings, you said that you opposed extending medical assistance because 18 months "is sufficient time to identify and treat most pressing health problems." That statement strikes me as totally out of touch with reality, regardless of what diseases refugees have when they arrive, they continue to walk in and use public medical facilities. A county hospital cannot turn away an indigent person just because they don't have a medicaid card. Let me give you some statistics from Jackson Memorial Hospital in Miami:

1. The hospital spent $18.2 million for services to refugees from October 1979 to August 1981;

2. They had 899 births to Haitian mothers in fiscal year 1980, and estimate 1450 for fiscal year 1981;

3. Inpatient services have cost an average $1,757 per Haitian patient, and $3,507 per Cuban patient.

The Federal government brought these people in, and they are using services and local taxpayers are bearing the costs. They will continue to use services regardless of what you do with the regulations. They will have babies, they will get sick, they will have accidents. All we are talking about is who pays the cost, the Federal government or local government?

Answer: There never has been a presumption that the Refugee or Entrant programs would cover all medical costs for refugees and entrants for some indefinite period of time. The current regulation does provide for 18 months of medical reimbursement to States and for those who are categorically eligible, medical assistance continues to be available for 36 months. There is no prospect of a medical assistance program for entrants and refugees which would cover births and other medical costs for as long as these might be needed.

The circumstances surrounding Jackson Memorial Hospital (JMH) require clarification. ORR has processed and approved all valid 1980 retroactive claims submitted by JMH. The State of Florida refused to process these claims, indicating that retroactive reimbursement could not be made by the State without prior contractual arrangements with service providers. ORR, therefore, worked with the State in processing these claims and authorized the State to make reimbursement.

In addition, not all claims submitted by Jackson Memorial could be acknowledged since some were for undocumented aliens or, at least, for persons who lacked documentation as entrants. On December 8, 1981 ORR revised its definition of eligibility under P.L. 96-422 to encompass all categories of entrants as set forth in Title V of the Fascell/Stone amendment. ORR made this policy applicable for all JMH claims between January 15, 1981, and December 8, 1981, and has worked with the State and JMH to process these claims. ORR has already provided advances to JMH for FY 1981 totalling $3.5 million and is prepared to reimburse JMH for additional allowable claims once these are presented by JMH and the State. To date, these claims have not been presented. The Department and ORR have taken a very accommodating posture toward JMH, and believe that, to the extent legally permissible, reimbursement has been made to JMH.

With respect to future impacts upon JMH and other health providers, Florida's share of ORR's proposed $35 million of targeted assistance for the entrant program provides relief to Florida to meet exceptional local medical needs. The State may determine that such needs represent an important use of its share of these funds.

PREVENTIVE HEALTH CARE

Question: The Committee is concerned with reports that there is a high incidence of tuberculosis among many refugees. To what extent does health screening abroad prevent refugees from posing public health problems when admitted to the U.S.?

Answer: The various agencies closely involved with the health screening of refugees are convinced that the present screening procedures and requirements are adequate to protect the public health. Since October 1979, approximately 300,000 Southeast Asian refugees have been screened for health conditions before leaving refugee staging areas in Southeast Asian.

The Centers for Disease Control (CDC) also coordinates a domestic health assessment program which is intended to include Southeast Asian refugees soon after their arrival in the United States. This program not only addresses the health conditions of public health concern, but also includes other conditions which can be an impediment to the effective resettlement of refugees. Refugees found with any of these health problems are treated or referred for treatment by State and local health departments.

Question: What are the most significant health problems of refugee currently admitted to the United States?

Answer: The most significant health problems of Southeast Asian refugees are those which are personal in nature, such as dental disease, anemia, and malnutrition. Although tuberculosis infection is the principal problem that has any degree of public health significance, the public health risk of Southeast Asian refugees with tuberculosis is negligible. Beginning with overseas screening and continuing with health assessments upon arrival in this country, Southeast Asian refugees are tested and thoroughly monitored for tuberculosis.

Question: What steps are being taken to ensure that appropriate follow-up care is provided refugees with health problems?

Answer: An excellent medical record documentation system was put in place at the beginning of the overseas screening program. The Intergovernmental Committee for Migration prepares the refugee's medical folder which includes an x-ray for tuberculosis, a record of the physical examination received (four copies), and an immunization form clearly identifying the vaccines received and those immunizations which need to be completed. This folder accompanies the refugees to the United States. State and local health departments receive notification of all arrivals by mail, copies of appropriate medical documents, and receive telephone calls within 24 hours from the ports of entry if a refugee has a medical condition which needs prompt follow-up in the refugee's area of initial resettlement. The Centers for Disease Control (CDC) then closely monitors the follow-up of these cases. To date, CDC records show that over 90 percent of these cases have been seen, evaluated, and treated, when necessary.

The domestic health assessment program coordinated by the CDC builds upon the basic public health screening conducted overseas and frequently adds an examination for various conditions of personal health concern. To whatever extent resources and capabilities permit, most health departments will treat refugees found to have these problems. Otherwise, refugees are referred to specialized diagnostic and treatment facilities within the community to receive whatever care might be necessary.

ALTERNATIVE APPROACHES TO REFUGEE ASSISTANCE

Question: The Committee shares the Administration's concern that refugees should not become part of a welfare cycle. Does the Department plan any organized approach, such as a State-wide demonstration, to test alternatives to the current welfare-oriented system of assisting refugees?

Answer: We are not currently considering a statewide demonstration to test an alternative to the present system of providing cash and medical assistance to refugees. We have, however, proposed that up to five percent of the refugee social service funds be used to test new approaches to resettlement and self-support, and we would expect to use some of those funds to try new approaches to increasing employment and reducing dependency.

Question: What are these?

Answer: We have only recently published a proposed allocation formula for refugee social services funds that would allow up to five percent of the funds to be used on such projects. Therefore, we have not finalized plans for such projects.

Question: Is a block grant program, granting considerable flexibility to States in handling refugees, a possible approach?

Answer: The President's Interagency Task Force on Immigration and Refugee Policy reviewed this question and concluded that the existing categories of refugee aid -- cash and medical assistance, training and services -- should be continued, together with reducing cash assistance to refugees who do not quality for the regular welfare programs. We are not currently looking toward a block grant approach. However, we have introduced greater flexibility with the proposed targeted assistance projects for Cuban and Haitian entrants and are proposing to do the same with respect to targeted assistance for refugees, for which funds are requested for FY 1983.

GENERAL ASSISTANCE COSTS

Question: The Department has apparently estimated that it will take $10 million for the balance of FY 1982 for General Assistance costs in States with General Assistance Programs. How was this assumption derived?

Answer: ORR's estimate of funds needed for General Assistance (GA) costs stems from the proposed change in cash and medical assistance policy. Under this proposed policy change, non-categorically eligible refugees would receive AFDC level benefits for their first eighteen months in the U.S., and then receive State or local GA for the second eighteen months if they meet the GA eligibility criteria. ORR estimated that only ten percent of the non-categorically eligible refugees would be eligible for State or local GA programs, and, thus, that $10 million would be required to cover those refugees. The figure of ten percent derived from an estimated 75 percent of non-categorically eligible refugees living in areas with acceptable GA programs and of those, an estimated 12 to 15 percent who would meet the GA eligibility criteria.

Question: Why do you not think it is low?

Answer: ORR does not believe that $10 million is a low figure because most State and local General Assistance programs have stringent eligibility requirements in order to receive assistance.

ORR PLACEMENT IN SSA

Question: Why was the Office of Refugee Resettlement transferred to the Social Security Administration?

Answer: ORR was placed directly under the Commissioner of the Social Security Administration (SSA) in order to allow ORR to receive program and administrative support from SSA. The move permits ORR, which relies on the income maintenance programs administered by SSA, to ensure that these programs are administered properly for refugees and entrants.

Question: How will this affect its visibility in HHS?

Answer: The Director of ORR reports directly to the Commissioner of SSA and maintains a direct reporting relationship to the Under Secretary of HHS. Thus, we believe that the move to SSA in no way diminishes the visibility of ORR.

Question: Is it anticipated that the Refugee Assistance Program will be administered in a more cost-effective manner under the Social Security Administration?

Answer: We believe so.

Question: If so, why?

Answer: By placing ORR in SSA, ORR becomes a part of one of the operating divisions of HHS. Such a placement enables ORR to receive substantial support in the day-to-day management of the program, especially as SSA has considerable expertise in the administration of income maintenance programs for the needy. This type of support was not available when ORR was within the Office of the Secretary.

RECEPTION AND PROCESSING PROGRAM

Question: The Committee understands that there is a significant shortfall of funding in FY 1982 for Cuban/Haitian Entrant Reception and Processing. Is it true that OMB originally approved a supplemental request for this program, but then decided to take funding from the Domestic Assistance account?

Answer: When the original FY 1983 budget request for the Refugee and Entrant Assistance Programs were submitted to OMB, it included a request for a supplemental appropriation in FY 1982 for the Entrant Reception and Processing Program. OMB approved that supplemental request initially. However, the supplemental request was subsequently withdrawn for several reasons. First, ORR found that there were unobligated FY 1981 funds in the entrant domestic assistance program that could be carried into FY 1982. States also estimated their FY 1982 funding needs for entrant domestic assistance at a lower overall level than ORR had anticipated. Finally, the additional funding needs in the entrant Reception and Processing Program decreased. As a result of these factors, ORR determined that sufficient funds existed within the entrant Assistance Program budget to cover the projected shortfall in the entrant Reception and Processing Program budget. Since available resources already existed, ORR and HHS felt that a supplemental request was not an appropriate action. Instead, a request for reprogramming of funds from the entrant Assistance Program into the entrant Reception and Processing Program will be submitted to the Congress shortly.

Question: How large is the funding shortfall?

Answer: The Office of Refugee Resettlement and the Department of Health and Human Services will request a reprogramming of $13 million from the entrant Assistance Program into the entrant Reception and Processing Program. These additional funds should be adequate to cover the estimated shortfall in Reception and Processing in FY 1982.

Question: The Reception and Processing Account has been moved by Executive Order to the Department of Justice. Why was this move made?

Answer: The transfer of the responsibility for the Cuban/Haitian Entrant Reception and Processing Program to the Department of Justice was made to increase the cost effectiveness of the operation of the program. In exploring alternatives to the continued use of Fort Chaffee, it was found that it is less expensive to use existing facilities of the Department of Justice to provide care to those entrants who remain in custody than to create a new resettlement facility run by the Department of Health and Human Services.

Question: How is management supposed to improve as a result of this shift?

Answer: The management of the Reception and Processing Program will be improved as a result of the shift in responsibility to the Justice Department because the personnel needed to maintain the facilities and to provide care for the entrants are already in place. Any alternative to the transfer to the Department of Jusitce would have involved some level of disruption to the program.

ENTRANTS IN DETENTION

Question: How many entrants remain in detention, either in camps or in Federal correctional facilities?

Answer: There are currently 1,353 entrants in the Atlanta Federal Correction Institute (FCI), including 217 former Fort Chaffee detainees. Thirty-seven entrants are in other FCI's, 105 are in mental health care in the Springfield FCI Hospital, and approximatgely 40 are held in Building B at St. Elizabeths Hospital.

Question: How many of the Cubans currently in detention could be released to communities with a sponsor?

Answer: Currently, 292 entrants have been cleared by the Immigration and Naturalization Service as "releasable" into communities. Office of Refugee Resettlement has been actively seeking sponsorships for these entrants, through voluntary resettlement agencies and non-profit corporations who have worked with this type of client in the past.

Question: Will the Federal government provide support for such sponsorship, and what is the likely cost?

Answer: ORR has grants in place for the sponsorship of this caseload, with an approximate cost of $5.3 million, and is actively seeking additional sponsorship opportunities for any additional caseload released by INS.

Question: In Fiscal 1982, what is your latest estimate of the cost of providing services and maintaining these detainees?

Answer: Since the Department of Justice is now responsible for Cuban/Haitian Reception and Processing, the Department of Justice would prefer to provide the most current information to the Subcommittee.

Question: How many Cubans in detention will require some kind of long-term care of supervision?

Answer: We can only respond about those Cubans with health care needs. Of those, approximately 520 will require mental health care, while another 3 are receiving continued medical treatment at the National Hansen's Disease Center in Carville, Louisiana. The Department of Justice which now has the responsibility for the

Cuban/Haitian Reception and Processing Program, would prefer to provide information to the Subcommittee on the other Cubans who will require some sort of long-term care or supervision.

Question: What is the probable cost of this care and which agencies will be responsible for expenditures in this regard?

Answer: Again, we can only respond about the health care provided to these entrants. In fiscal year 1983, $14 million has been requested through the Department of Justice for the mental health care of detained Cubans place in non-Fedeal facilities for care. This placement activity is expected to be tasked by the Deprtment of Justice to the Department of Health and Human Services (HHS). Long-term mental health care for Cubans remaining in Federal physical custody is a cost for which the Department of Justice is responsible. Approximately $100,000 will be required by HHS for the care of Cubans with Hansen's Disease.

The Department of Justice would prefer to provide the relevant information on the non-health care costs of these Cubans.

Question: What has been done to attempt to return this group to Cuba?

Answer: The Department of State has requested that they be permitted to respond directly to the Subcommittee on this question.

SUBCOMMITTEE RECESS

Senator CHILES. The meeting is recessed.

[Whereupon, at 11:55 a.m., Wednesday, March 10, the subcommittee was recessed to reconvene at the call of the Chair.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

FRIDAY, MARCH 5, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:03 p.m., in room 1318, Everett McKinley Dirksen Senate Office Building, Hon. Warren Rudman presiding.

Present: Senators Rudman and Burdick.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF HUMAN DEVELOPMENT SERVICES

STATEMENT OF DORCAS R. HARDY, ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

ACCOMPANIED BY:

- **LENNIE-MARIE P. TOLLIVER, COMMISSIONER, ADMINISTRATION ON AGING**
- **CLARENCE HODGES, COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES**
- **ANTHONY L. ITTEILAG, DEPUTY ASSISTANT SECRETARY, BUDGET**

OFFICE OF COMMUNITY SERVICES

STATEMENT OF:

- **ROBERT L. TRACHTENBERG, ACTING DIRECTOR**

ACCOMPANIED BY:

- **ROBERT J. RUBIN, ASSISTANT SECRETARY, PLANNING AND EVALUATION**
- **RICHARD P. KUSSEROW, INSPECTOR GENERAL**
- **BETTY LOU DOTSON, DIRECTOR, OFFICE FOR CIVIL RIGHTS**
- **A. PRENTICE BARNES, CHIEF, FORMULATION BRANCH, DIVISION, OFFICE OF SECRETARY**

SUBCOMMITTEE PROCEDURE

Senator RUDMAN. The subcommittee will come to order.

This afternoon, we will hear testimony concerning human development programs and management activities of the Department of Health and Human Services.

The principal witness discussing human development programs is Assistant Secretary Dorcas Hardy.

Also here to testify is Mr. Trachtenberg who heads the Office of Community Services.

The programs under the jurisdiction of the Assistant Secretary for Human Development include: Head Start, child abuse, runaway youth, nutrition and social services for the elderly, development disabilities, and services for native Americans, as well as the existing social services block grant and the proposed child welfare block grant.

Mr. Trachtenberg's office administers the antipoverty programs previously operated by the Community Services Administration.

We have asked that the testimony not include the proposed transfer of vocational rehabilitation and special institution programs since they will be considered during the Department of Education hearings.

For the second part of today's hearing, the Assistant Secretary for Management and Budget will testify on budget requests for the Inspector General's Office, the Office of Civil Rights, and departmental management and policy research activities.

We will begin with Assistant Secretary Hardy.

Your entire statement will be incorporated in the record. We would appreciate it if you would summarize your remarks.

OPENING REMARKS

Assistant Secretary Hardy. Thank you, Mr. Chairman.

First, I would like to introduce you to two of my colleagues who are here with me today.

INTRODUCTION OF ASSOCIATES

Lennie-Marie Tolliver, who is Commissioner of the Administration on Aging, and Clarence Hodges, Commissioner of Children, Youth, and Families.

My testimony has been submitted for the record, but I want to take this opportunity to make a few remarks that will provide a framework for this $4.8 billion budget request.

A common goal of all Human Development Services programs is social and economic self-sufficiency, and we believe the policy of sound economic growth is the best means of promoting social and economic self-sufficiency for the largest number of needy Americans.

We are committed to restraining Federal spending as an essential part of the successful implementation of the President's economic recovery program, and we are convinced that a combination of these reductions, plus economic growth will result in long-term social and economic self-sufficiency.

Our request is based on the belief that the primary responsibility for responding to social and economic needs lies with individuals and families, and the communities in which they live. When there is need for assistance, and that does arise, that assistance is best defined and administered through public and private institutions at the level closest to the problems, such as State and local governments, area agencies on aging, local grantees, and private organizations.

Therefore, Human Development Services has very consciously structured services toward fostering independence of our citizenry rather than increasing its reliance on public support.

We are requesting substantial resources to be directed to the most vulnerable Americans. One example is the Head Start program. And we believe that the funds requested are intended to meet the Federal Government's share of responsibility to those who are truly in need.

In summary, I would like to say that our budget assumes a share of responsibility for national economic recovery. We propose to administer our resources with a view toward maximizing optional efficiency and effectiveness. We want to foster individual, State, and local responsibility and authority to maintain programs for the truly needy.

Our budget provides for Federal participation and funding for programs administered by State and local authorities. At the same time we are committed to maintaining direct Federal management of those programs that respond to priority national concerns.

Thank you. I would be glad to answer any questions.

Senator RUDMAN. Thank you, Ms. Hardy.

Because of the number of programs involved, we do have a number of questions. I am going to ask a number of them here today, but they are so numerous that I expect that we will ask you to answer a number of them for the record.

Assistant Secretary HARDY. All right.

OFFICE OF COMMUNITY SERVICES

Senator RUDMAN. Does Mr. Trachtenberg wish to have any opening remarks?

STATEMENT OF ROBERT L. TRACHTENBERG

Mr. TRACHTENBERG. Yes; I will make a very brief one, Mr. Chairman.

The Office of Community Services is a new organization within the Department of Health and Human Services during this fiscal year. It has three basic administrative functions: The funding of community services block grants; the funding of transition grants to grantees in States that did not opt for the block grant; and overseeing the closeout of the activities of the Community Services Administration. Basically, these are grant-contract activities.

In fiscal year 1983, we will have basically two activities: Continuation of the block-grant function for which we are requesting $100 million; and the final closeout of the community services activities that has been started this fiscal year.

We are requesting $6.3 million for administrative expenses which will cover salaries and expenses for both the block grant as well as closeout activities. Also, $6.2 million is requested for funding supplements to former CSA grantees to close out all the fiscal responsibilities that they may have.

The request for the $100 million is a significant reduction from the continuing resolution level of this year. The Secretary was faced with making some very difficult choices in establishing priorities. He felt that he had to hold the line on some programs like Head Start and has, indeed, done so.

I think it is time that community action agencies continue to move as they have in the past toward greater self-sufficiency without continued funding on the part of the Federal Government. Community action agencies have been receiving funds for approximately 17 years now, and this budget will help in phasing down their Federal reliance. At the same time, we anticipate that they will continue their efforts, which have been outstanding up until now, in obtaining funds from private sources, and other funding agencies, including HHS.

That concludes my statement.

REDUCTION IN FORCE AT OHDS

Senator RUDMAN. Thank you very much.

Ms. Hardy, the newspaper accounts of the impact of RIF's in your agency have indicated the possibility certainly of major disruptions resulting from bumping senior staff in areas in which they are familiar into areas with which they may not be familiar.

In fact, one Council on Aging expert said the Head Start program to which he had been bumped was going to suffer to some extent because he had to learn a new job, which is understandable.

I have three or four questions in this area. First, how many people actually have been bumped into new jobs as a result of the reduction in force?

Assistant Secretary HARDY. We have had 44 people separated from the Federal service—144 people were downgraded within Human Development Services, and 121 were reassigned.

Senator RUDMAN. From your own observations, have you had much indication of a reduction in quality of work from these people in new areas?

Assistant Secretary HARDY. I think, Senator, when there is a reduction in force there is always a period of adjustment. But I think now we are beginning to see a turnaround.

The Office of Human Development Services was very supportive of its employees during this RIF. We have done a lot to help the people affected through placement and support through an active job club.

Perhaps some of the stories about low morale reflect a sense on the part of some employees that a RIF is perhaps not the fairest way to reduce a workforce, whether Federal, industry, or whatever.

Senator RUDMAN. Was there any thought of or discussion given over there to making this reduction through attrition?

Assistant Secretary HARDY. We have had a hiring freeze, Senator, since last summer. We have had vacancies that we have not filled, and we were able to use those during the RIF to help reduce its impact.

Senator RUDMAN. I wonder if you might tell me whether or not you are reducing the number of schedule C political appointments over there below the level of the Carter administration?

Assistant Secretary HARDY. Yes, sir.

Senator RUDMAN. By how many?

Assistant Secretary HARDY. I would have to look on the list, but I believe when I first came into this position we had 25 schedule C positions. We now have 17.

I can submit a count to you, but we have substantially reduced our schedule C positions.

STATE IMPLEMENTATION OF BLOCK GRANTS

Senator RUDMAN. One of the areas of concern of this subcommittee within this whole broad range of areas has been the fear that when the States implement these block grants, there could be a creation of new layers of administration, if you will, that would lead to a cutback in essential services that should be provided.

What are you doing to insure that doesn't happen?

Assistant Secretary HARDY. First of all, the block grant started 5 months ago. The States are doing a good job, and they are making their own decisions about how to spend those dollars. We have had conversations with many of the State people. They are targeting their services to the most needy and are coming up with some very creative ways to provide the services needed.

Senator RUDMAN. Do you think some report or bill language ought to be adopted to assure that overhead is minimized and the basic services are provided?

Assistant Secretary HARDY. In my conversations with State people, I do not think that is necessary.

Senator RUDMAN. You feel you can do it administratively?

Assistant Secretary HARDY. I think we can work with the States. And I think the States are very aware that they have the responsibility to provide services.

LEVEL OF SERVICES PROVIDED IN FISCAL YEAR 1983

Senator RUDMAN. I believe that you are probably familiar with a study by the National Association of Social Workers that estimated fiscal year 1983 budget requests would eliminate some services such as day care and homemaker aid for about 3 million people. Your fiscal 1983 budget justification conspicuously lacks any estimate of service levels to be provided in either fiscal years 1982 or 1983.

Can you tell us whether those reports are accurate, that the level of 7.7 million people receiving social services will decline to about 4.4 million recipients in fiscal year 1983?

Assistant Secretary HARDY. I do not think those figures are accurate. As I understand the study, they are proposing a straight-line projection of all 1981 versus what they assume is all 1982. We are only in the fifth month of States picking up the social services block grant and I don't think they can make the assumption that the States are going to do exactly what they did last year this year.

States are making innovations. And I think we are going to see many of the same people, the majority, getting the same kinds of services or even better services because States are going to be delivering them more effectively.

Senator RUDMAN. When do you feel we could get a good estimate of what that number will actually be?

Assistant Secretary HARDY. I would suggest that that would probably be sometime this summer. We are in constant contact with the States, working with them and supplying the assistance they ask us for.

COMMUNITY SERVICES BLOCK GRANT

Senator RUDMAN. I would now like to turn to an area that is a very substantial concern, not only to this subcommittee, but to our counterpart in the House.

It well may be that Mr. Itteilag who appears at all of these hearings may be able to participate in the dialog with the subcommittee here this afternoon.

I want to talk about a number of things. We will start out with viable community services block grants. You are proposing to cut the community services block grant back to $100 million from the fiscal year 1982 level of $348 million. In fiscal year 1981, the comparable programs were funded through CSA at $525 million.

The first question is whether or not $100 million is going to be enough to sustain any meaningful—and I emphasize the word "meaningful"—nationwide network of local community action agencies.

COMMUNITY ACTION AGENCY EARMARKS

Mr. TRACHTENBERG. I would like to address that question, Mr. Chairman.

There is no question that there is a very significant reduction in the amount of the request for new budget authority; however, I would like to make several points.

The first is that in fiscal year 1983, under the Community Services Block Grant Act, the law does not require that States fund community action agencies. They were given a leg up in fiscal year 1982 by being identified as an eligible entity for recipient of funds, however in fiscal year 1983, States could turn all their money to political subdivisions.

This point, I think, is significant in the sense that this gives the States the opportunity to make some very tough decisions as the Secretary had to make in terms of coming up with the fiscal year 1983 budget for OCS.

The States have to make some very tough decisions in terms of what works and what doesn't work.

There is no guarantee that any community action agency will continue. I believe that those that are performing effective services will continue and they will have to negotiate new agreements with many of the categorical programs which they support. In addition, they are going to have to work out other arrangements in terms of administrative costs for some of these categorical programs.

I think it is difficult to determine how many community action agencies will indeed survive. But as I said, the Block Grant Act itself, that Congress enacted, does not give them a guarantee of funding in fiscal year 1983.

CONSOLIDATION OF COMMUNITY SERVICES AND SOCIAL SERVICES BLOCK GRANTS

Senator RUDMAN. Well, that being the case, what is the rationale for maintaining it at all rather than simply merging it with the activities of the human services block grant?

Mr. TRACHTENBERG. Mr. Chairman, I believe at one point, that was the administration's proposal and was subsequently broken out separately.

Senator RUDMAN. Why not come back with the original proposal again if you believe that is the right thing to do?

Mr. TRACHTENBERG. I could take that up with the Office of the Secretary.

Senator RUDMAN. It just seems that this is the name we are talking about. It might, in terms of economies of scale, be better to have it incorporated with some larger amounts of funds that could have some meaning. I seriously question whether this will do anything other than maintain the jobs of some administrative people.

And it doesn't seem to make any sense from an economic point of view or an operational point of view.

Mr. TRACHTENBERG. As I said, that was the original proposal, Mr. Chairman. And the Secretary——

HEAD START

Senator RUDMAN. Well, you might come back with it; you came back with a lot of proposals for the second time.

We have a number of other questions in this area for the record.

I want to turn to the Head Start program currently administered by community action agencies. What is going to happen to that program when those agencies close their doors?

And, let me point out to you that in my State, low-income energy assistance projects and weatherization projects, which are absolutely essential, are administered by those agencies. What would the plans be for changing their administration?

Assistant Secretary HARDY. In terms of Head Start, many of those people have been working with the local Head Start grantees. We think that the support the CAP's are providing can be provided by Head Start grantees themselves, or they can come up with other mechanisms.

We certainly don't anticipate in any way that the Head Start program in your particular area would not survive because the CAP was not there.

ADMINISTRATION OF ENERGY ASSISTANCE PROGRAMS

Senator RUDMAN. What about these other kinds of programs, not just in New Hampshire, but elsewhere? We have weatherization projects, low-income energy assistance programs in these areas. We are now going to set up a whole new set of administrative agencies and end up with administrative costs, compared to what they were, that would be much higher.

Mr. TRACHTENBERG. I would hope not. The low-income energy program is a separate block. And again, this gives the State the flexibility of deciding which service organization is most effective for delivering services in that area. And where a community action agency has been doing a good job, the States have the flexibility of continuing with the community action agency.

They will be performing at a reduced level in terms of the core support that is being provided, but I don't think this necessarily means that a community action agency which is doing a good job and receiving low-income energy money, for instance, would necessarily have to close their doors.

Senator RUDMAN. Well, you have done a remarkable job, then, in some of these areas. This low-income energy assistance is only a small part. And weatherization is a very substantial part. But the figure that I got yesterday was astonishing to me.

We have had probably the worst winter in my memory, and I have spent a lot of time in New Hampshire—the coldest winter, most snow, most difficulty. And yet, the State of New Hampshire this year consumed 40 percent less fuel oil than last year, which was a warm year.

That has a lot to do with cost. The people can't afford it. It also has a lot to do with the weatherization projects that have been funded by the Federal Government. It has a lot to do with weatherization problems that have been resolved by individuals and private organizations.

I would hope that the administration of these programs and similar programs would not drop through the cracks. It is absolutely essential. I have faith in my State these programs will be continued by someone because they are important. But I would hope we don't have an interregnum here that ends up with a year or two where these programs are being very poorly administered.

DISCRETIONARY FUND

I want to turn to an area that was of exceptional concern to this subcommittee and our counterpart. And I would just like to say to you that I would like you to consider your answers to these questions very carefully.

Under the continuing resolution, the Office of Community Services was authorized and directed to spend $31.3 million for four programs authorized under the Secretary's discretionary fund. To date, plans have been announced to spend only $5 million of that money.

My first question—and I don't know who wants to answer this, but I would like the person most qualified to answer it—when are these funds going to be obligated and in the amount and manner directed by Congress?

Mr. TRACHTENBERG. Mr. Chairman, I hope you will be pleased to know that the Secretary has forwarded a request to the Office of Management and Budget for a reapportionment which requests approximately $31 million for discretionary programs that you just made reference to.

We in the Office of Community Services are now preparing a program announcement which will identify the areas of priority, involving programs of regional and national significance, under which we would consider in order to support $31 million for this program.

HEALTH AND HUMAN SERVICES INTERPRETATION OF DISCRETIONARY FUND AUTHORITY

Senator RUDMAN. Mr. Trachtenberg, was there ever any question in your agency that the language contained meant precisely what I think it means? I think you know what I think it means. Was there any legal opinion from anybody over in your agency or from OMB that questioned what that clear language meant?

Mr. TRACHTENBERG. Mr. Chairman, I think there was.

Senator RUDMAN. Do you have a copy of that?

Mr. TRACHTENBERG. I have a copy of various issue papers, of statutory references, that are involved in this matter. But the earlier opinion of our general counsel was that the more restrictive language was the Senate language. I would refer you to the Senate committee report which says that the Secretary is directed to maintain the most vital, ongoing programs, and that the goal was to give as much of the funds to the State for the community services block grant.

Senator RUDMAN. No; as a lawyer and as a former attorney general, we wrote all kinds of opinions. I know something about language shopping. And I think this is a good example of language shopping.

Is your general counsel here?

Mr. TRACHTENBERG. I don't think so, sir.

Senator RUDMAN. I wish he was. I would like to discuss the language. The language picked was clearly referred to and interpreted on the floor of the Senate, and later clearly changed in conference. And a number of questions have been asked by a number of people as to why there has been this language.

Now, I take it that since the request has now gone to OMB that the general counsel has changed his mind; is that correct?

Mr. TRACHTENBERG. The general counsel has given the Secretary a revised opinion. And what basically occurred was the realization that on the Senate floor, all the agreements that were contained in the second continuing resolution were picked up in the third continuing resolution. Based on the revised general counsel opinion, the Secretary has sent his request to OMB.

Senator RUDMAN. Well, Mr. Trachtenberg, I know you are probably the wrong fellow to address this to. It is like the fellow who killed the messenger who brought the bad news, but I will give you the message to take back to your general counsel.

We spent a great deal of time developing language on that continuing resolution. We spent something like 3 days straight in conferences with a few hours off for sleep—I am sure you remember that period—with these committees and on the floor of the Senate, trying to work out language to address the large number of areas that were of legitimate concern to both the members of the House and Senate Appropriations Committee.

We finally adopted, and the staff worked and cleared it with the members, the language that we thought was going to be applicable.

Now, so many months later, we find that the general counsel suddenly realizes that something happened back there which makes his prior legal opinion subject to modification. You know, it seems to me that we have ample communications around here. You have got enough legislative liaison people from the agencies to staff a combat division. It would seem to me that they might be able to come up here and ask us a question or two.

We have a pretty good staff. They have good memories.

When someone is going to issue an opinion that flies in the face of what a number of members of the committee passed onto the agency, I think it is incumbent upon anyone who is issuing that kind of opinion to at least find out whether or not somebody else knows something that they don't know.

Now, I know that is not your fault. But I hope you will carry the message back because I don't like it one bit. I think this Congress will, you know, do what it ought to do and let you do what you ought to do, but when we write a law and we say something and go to the trouble of putting into it a colloquy of the floor and go to the further trouble of putting into it a conference report, and then some lawyer down in an agency says it doesn't count, and he is looking at the language—I don't happen to like it.

I wish you would pass this message back because, frankly, we will deal with it in other ways in the future.

Mr. TRACHTENBERG. With all due respect, Mr. Chairman, I thought I was bringing good news.

Senator RUDMAN. You did; you brought very good news, but it is 6 months too late.

Mr. TRACHTENBERG. Those funds will be spent, sir.

Senator RUDMAN. Well, I hope some of those funds haven't already gone out to some of the States, and you have to reclaim the money to transfer it under that continuing resolution because if you have, you are going to have some people up there angry at you that shouldn't be.

Mr. TRACHTENBERG. There are still two quarters in which to make the corrections.

RURAL DEVELOPMENT LOAN FUND

Senator RUDMAN. Mr. Trachtenberg, my displeasure is not directed at you, but at somebody who works with you. And I hope you will pass that back.

I assume the same answer would apply to the rural development loan fund?

Mr. TRACHTENBERG. That is a separate issue, Mr. Chairman. There is authority to fund the rural development loan fund under the 9-percent set-aside. But there are also funds available in the loan fund itself. And those same lawyers—and I don't want to get you upset by it—are looking at the issue of the funding of the rural development fund.

CHILD WELFARE BLOCK GRANT

Senator RUDMAN. I won't get upset. It depends on the conclusion they reach. I suggest they might make a phone call before putting their imprimatur on their opinion because there are some people up here that might disagree with that.

I wonder if you might tell me what the status of your legislative proposal is to consolidate child welfare services, child welfare training, foster care, and adoption assistance into a single, flexible block grant?

Assistant Secretary HARDY. The proposal should be up here shortly. We are in the process of putting together the final language. I think the overall emphasis of the child welfare block grant will be on not only combining those categories of funds, but also on keeping in the protections and the safeguards that were in 96–272.

Senator RUDMAN. When do you expect to have that?

Assistant Secretary HARDY. It is at OMB so it should be a couple weeks, sir.

Senator RUDMAN. I want to turn now briefly to impact of child welfare block grants on discretionary services. You are requesting $380 million for the proposed new child welfare block grant. In fiscal 1982, $465 million has been appropriated for comparable programs of which $305 million is for foster care, adoption assistance, and entitlement payments.

As you know, Congress has rejected previous proposals to cap these entitlements. Assuming Congress is again unwilling—and that is just an assumption, not necessarily my assumption—to place a cap on these payments in 1983, isn't there a danger most of the $380 million budget request would be absorbed in mandatory foster care payments with very little left over for child welfare and training services?

Assistant Secretary HARDY. One of the reasons we are proposing the block-grant concept is so that the States will be able to look at those dollars and make those decisions. The incentives for using those moneys in child welfare services will still be retained so that they will be moving children out of foster care into a permanent family situation.

Senator RUDMAN. Would you not risk defeating the purpose of the law which is intended to deemphasize your reliance on foster care and get children in permanent adoptive homes? Isn't there a risk this should happen?

Assistant Secretary HARDY. You mean risk of it backfiring so to speak?

Senator RUDMAN. Yes.

Assistant Secretary HARDY. We don't think so. I think anything is possible, but I don't think that is at all probable. Many of the States, 34 of them, have met many of the protections of 96–272. They are with this program and are working hard to meet all of those safeguards and keep moving children out of foster care into permanent situations.

HEAD START

Senator RUDMAN. Let's switch for a moment to the Head Start budget. I am trying to get through all of these areas with the most significant questions. There are many here we will submit to you for the record.

Your request claims there are going to be no reductions from the current level of 377,000 children served by Head Start, despite the fact that local grantees will receive only a $5 million increase in 1983 which is less than 1 percent.

It seems to us that there is a reversal in the administration's position that management efficiencies will now permit local grantees to offset inflation, to provide salary increases, and maintain quality service when last year the budget argued for significantly increased funding to avoid deterioration in those services.

That was the justification last year. I don't know whether you were here last year with that or not.

Assistant Secretary HARDY. Well, I was not here.

We did request an additional $93 million for the 1982 budget and are requesting level funding for 1983. The dollars are being spent for increased salaries and reducing the number of children in classrooms.

After coming up with the solutions or ideas that we have laid out in the Head Start strategy paper, we feel we could make a lot of management savings within our Head Start programs and help them to retain the level of children served as well.

Senator RUDMAN. Then, I take it you feel that there is no great risk of deterioration of the quality of these programs?

Assistant Secretary HARDY. That is correct.

CHILD ABUSE

Senator RUDMAN. Well, I certainly hope you are right.

Your budget justification cites a 17-percent increase in reported child abuse cases in the last 2 years. The budget, of course, cuts funding from $6.7 down to $4.6 million for fiscal 1983.

Is it your intent to phase out all currently funded prevention and treatment projects in order to limit the Federal role strictly to technical assistance and dissemination of information?

Assistant Secretary HARDY. I see that there will be more technical assistance and dissemination of information, but we are also concerned about prevention of child abuse.

The States and many private organizations are very much involved in this area. We think with the reduced funds, the program will still be very viable and at the appropriate levels.

Senator RUDMAN. Senator Burdick, I understand that you have some questions on a particular program. And I would be very happy to yield to you at this time since we do have, I think, a fairly long hearing here. And if you would like to ask your questions in that program or wait a while, it is certainly up to you.

WORK INCENTIVE PROGRAM

Senator BURDICK. Are we dealing with the work incentive program? Is that encompassed in what we are talking about?

Senator RUDMAN. I believe that is within your jurisdiction.

Assistant Secretary HARDY. Yes.

Senator BURDICK. Work incentive program?

Assistant Secretary HARDY. Yes, sir.

Senator BURDICK. I appreciate very much the accommodation of the chairman. It would be very helpful.

Senator RUDMAN. We would like you to go ahead and ask a question on the WIN program. We would be very happy to resume our normal schedule thereafter. So I will yield it to you.

Senator BURDICK. Thank you, sir.

Whoever has this portfolio, it is my understanding that in fiscal year 1981, there were 3.5 million families enrolled in aid to families with dependent children and that there were 1,155,711 who were registered in the work incentive program.

Of these registrants, I am told that 310,303 got jobs at an average hourly rate of $4.17, and that nearly 90 percent held their jobs for at least 30 days, the end result being that for every WIN dollar spent nationwide, $5.98 was stimulated through wages.

In my own State of North Dakota last year, there were 104,000 WIN registrants, 622 of whom entered employment. The total cost of the North Dakota program was $956,525 which generated $3,701,344 in wages. In other words, for each dollar invested in North Dakota, $5.19 was stimulated.

Given these national and State statistics, why should a proven successful program that has the effect of reducing the welfare rolls and placing people in jobs where they can have a sense of self-worth be eliminated?

How successful have the demonstration programs been in reducing welfare costs and in providing self-sufficient employment?

That is a two-part question. You can take either one or both.

Assistant Secretary HARDY. My first comment is that we are very concerned about job training services and work incentives as a policy to help provide ways for AFDC welfare recipients to become self-sufficient.

At the same time, the WIN program is currently operated as a categorical program. It is proposed for no funding in 1983 because of the proposed mandatory CWEP program that is currently going through the legislative process.

We recognize that we can do without a categorical program like WIN in the Federal Government.

I also think there are other opportunities for continuing WIN programs at the State level through the social services block grant, through the new Department of Labor employment and training block that is being proposed, through the community services block grants, and through other block grants that are going to the States.

Senator BURDICK. Of course, it would seem that investment of $956,000 that generates $3.7 million is a program we should keep and not defer it to be included in some other program that might not sail.

Assistant Secretary HARDY. Regarding the CWEP program—and I would have to defer this point to the Social Security Administration and Office of Family Assistance which is responsible for that—there are several States that picked the CWEP option and are operating those programs. We could certainly look at the cost benefit of those. And I would venture to say that the CWEP program would be as cost beneficient as the WIN program has been.

Senator BURDICK. Well, do I understand, then, that you are recommending that the WIN program be zeroed out?

Assistant Secretary HARDY Yes, sir.

WORK DEMONSTRATION PROGRAMS

Senator BURDICK. I wonder if you would answer the second part about work demonstration programs. Did you include that in your answer, too?

Assistant Secretary HARDY. I believe I have; yes, sir.

Senator BURDICK. That, too, will be zeroed out?

Assistant Secretary HARDY. WIN demonstration programs?

Senator BURDICK. WIN demonstrations.

Assistant Secretary HARDY. The WIN demonstration programs, as I understand it—and again, this is a little out of my area—are funded through WIN dollars and 26 States have requested demonstrations. There will probably be 16 or 17 which will go through that program this year.

Those will be allowable under the new proposals, whether it is CWEP or people using block grants, or whatever, in terms of providing more incentive training programs.

Senator BURDICK. But that would be the end of it?

Assistant Secretary HARDY. Yes, sir.

Senator BURDICK. Thank you, Mr. Chairman.

RUNAWAY AND HOMELESS YOUTH PROGRAMS

Senator RUDMAN. Thank you, Senator Burdick.

Ms. Hardy, let's turn to the youth programs. Your justification indicates about 440,000 youth will be served with the $10.5 million fiscal 1982 appropriation of runaway and homeless youth programs.

How many persons would be served in fiscal 1983 at the $6.6 million budget request level for runaway youth programs?

Assistant Secretary HARDY. I do not have the specific number, Mr. Chairman. But I think I would like to point out in terms of the runaway youth programs, Federal dollars represent perhaps 25 or 30 percent of the entire runaway youth programs throughout the country.

So I feel there would be an equal number of programs, perhaps even more, sir.

Senator RUDMAN. Do you feel some of the small amount of slippage would be made up at the local and State level?

Assistant Secretary HARDY. Yes, sir; I do.

Senator RUDMAN. Do you have any idea of how many of the 165 runaway youth centers that now exist, which are funded in a variety of ways, would no longer receive any Federal support at all?

Assistant Secretary HARDY. I think we could make estimates about that, but it requires looking at the whole competitive process and what kind of dollars people are requesting. There would be a question as to whether all centers should receive *x* percentage cut from last year or whether we should target on particular centers and particular localities, or look at the kinds of matches they have from the private sector. Those decisions have not yet been made.

TRANSFER OF SURPLUS COMMODITY PROGRAM TO HHS

Senator RUDMAN. Let's move on briefly to the agriculture surplus commodities programs. Your budget request recommends transferring the Department of Agriculture's surplus commodities program to your agency, merging it with your nutrition for the elderly programs.

Why should we agree to the transfer in view of the fact that we have just passed a 3-year renewal of the Older Americans Act that keeps this program as a separate entity in the Agriculture Department?

Assistant Secretary HARDY. We proposed the transfer at the time the Older Americans Act was going through reauthorization. We would still like to see this happen.

Senator RUDMAN. Doesn't it seem a bit inconsistent? You are talking about, you know, musical chairs. You have the Congress saying the Older Americans Act should stay in the Department of Agriculture, and that's where it is.

Assistant Secretary HARDY. No; we are suggesting the commodities program at Agriculture, come to us. We feel it could be administered better in terms of the overall Older Americans Act and whole nutrition program, and that we would be cashing out that program.

Senator RUDMAN. I understand that, but it does seem somewhat inconsistent, but nothing around here requires consistency in everything.

Assistant Secretary HARDY. That's true, sir.

DEVELOPMENTAL DISABILITIES

Senator RUDMAN. Turning to developmental disabilities State grants, the budget request for the developmental disabilities State grants is $24.7 million, a cut of $16.8 million below the current level.

Can you tell us the impact of that cut, which is about 40 percent, in this very small State grant program?

And second, would you in your answer also tell us whether or not you believe you leave enough money for any kind of a viable State grant program, especially if Congress approves your language to remove the statutory minimum $250,000 State grant?

Assistant Secretary HARDY. We think that it will provide for good State programs. The dollars that are going to the developmental disability programs in the States, the State councils, and their coordinating bodies are combining with all sorts of resources throughout the States. We have a responsibility to the disabled, and we want to maintain that responsibility.

We think there are ways that DD programs could be using other resources throughout that State without having it all come from the Federal Government.

PHASEOUT OF UNIVERSITY AFFILIATED FACILITY PROGRAMS

Senator RUDMAN. Well, that may be true, but in our State, we do receive the minimum grant like many small States of $250,000. And under this proposal, the grant would be reduced to $97,000 in a State which already has enormous budgetary problems.

So I would just very politely challenge your response and tell you that it won't happen.

It is reported that the Administration on Developmental Disabilities is currently considering the proposal which would eliminate funding in effect for an estimated 16 university-affiliated programs, UAF's, while doubling funding for certain remaining UAF programs.

In addition, it is reported that you are considering the total elimination of UAF funding within 3 years.

Would you tell us why you are doubling funding for these programs in this fiscal year when there seems to be some plan to eliminate them later on?

Assistant Secretary HARDY. All of what you just reported has been discussed.

Senator RUDMAN. I hope so.

Assistant Secretary HARDY. We fund approximately 36 UAF programs out of the 49 throughout the country. Four years ago, Congress asked us to put together standards for university-affiliated facility programs. We have done that and now feel that we need to go out and compete many of these grantees to see who is up to the standards and who is not.

I would estimate that 20 to 24 of the programs might be funded. I don't know that exact number—but there will be competition among those 36. And I would not assume that everybody is going to make it.

The concept of eventually phasing out university-affiliated facilities is part of our thinking. And whether that happens over a 3-year or longer period, we feel that it is a legitimate kind of thing that could happen.

We have been funding these programs for 20 years and believe there should be an end at some point to Federal administrative responsibility for these centers.

COORDINATION WITH OFFICE OF MATERNAL AND CHILD HEALTH

Senator RUDMAN. The Developmental Disabilities Act requires expenditures for UAF's authorized under that act be coordinated with expenditures under the maternal and child health block grant. In developing your recommendations for UAF's under the act, what coordination have you undertaken with the Office of Maternal and Child Health which also funds UAF's?

Assistant Secretary HARDY. My staff and I have met with the Surgeon General and staff of the Bureau of Maternal and Child Health to discuss the whole issue of UAF's and what our role should be. I understand that maternal and child health is decreasing some of their funds to UAF's.

We have kept them involved in our discussions, and will continue to do so.

NATIVE AMERICAN PROGRAMS

Senator RUDMAN. The fiscal 1983 budget request for native Americans is $23.3 million, a cut of nearly $5 million from the current funding level and more than $10 million below the fiscal year 1981 levels.

Specifically, what types of activities are being cut in fiscal year 1982 and what further aspects of native American programs will be curtailed in fiscal 1983?

Assistant Secretary HARDY. In terms of the native American program, it is a question of prioritizing within the broad philosophy of the social and economic development strategy—SEDS. The philosophy of the SEDS strategy is being applied by the Administration to Native Americans to all tribes. All tribes who are applying for grants must be demonstrating that these funds are being used for social and economic development, so that our dollars have some kind of a long-term impact on those tribes.

We will use that same kind of criteria with the budget decreases proposed for the next year.

Senator RUDMAN. Ms. Hardy and Mr. Trachtenberg, I want to thank you very much. You have given us your answers for the record which is what we wanted.

PREPARED STATEMENTS AND SUBMITTED QUESTIONS

We have a number of other questions getting into some specifics which we will ask for and will furnish to you, and you can return to us any answers with corrections to the record you wish to make.

We appreciate your being with us.

[The statements and the following questions which were not asked at the hearing but were submitted for response for the record follow:]

STATEMENT OF DORCAS R. HARDY

I am pleased to appear before you today to discuss the fiscal year 1983 budget request for programs administered by the Office of Human Development Services. A total of $4,827,262,000 is requested to support social programs which serve children and youth and their families, the elderly, the handicapped, those who are developmentally disabled, and Native Americans. Of the total requested, $1,974,126 000 is requested for the Human Services Block Grant appropriation; $2,415,725,000 is requested for the Services to Selected Groups appropriation; $57,291,000 is requested for the Human Resources Research and Demonstration appropriation; and $380,120,000 is requested for the Child Welfare Block Grant appropriation. No funds are requested for the Work Incentive Program. Nor is new budget authority requested for Scientific Activities Overseas. In 1983, this program will be supported from funds appropriated in prior years. Our budget request for these programs is consistent with the President's budget policy to restrain Federal spending. The consolidations proposed in this budget request are consistent with the Administration's policies to increase State flexibility to program and administer resources and to simplify Federal administrative and oversight responsibilities.

A level of $1,974,126,000 is requested for the Human Services Block Grant to continue support for a variety of social services at the State level. This is the same level which the President proposed in his September budget revisions for 1982. Services which a State may choose to provide may include, but are not limited to: child and adult day care services, protective services, foster care, transportation, family planning, training, information and referral, counseling, delivery of meals, and health support. It is expected that States will eliminate unproductive projects and target resources on those who are most in need.

A level of $2,415,725,000 is requested for the new Services to Selected groups appropriation. This appropriation includes many programs which were formerly in the Human Devlopment Services appropriation, as well as Rehabilitation Services and Special Institutions previously administered by the Department of Education.

> The President's commitment to the Head Start program is reflected by a 1983 budget request of $912,000,000. The amount requested will support the delivery of comprehensive child development services to 377,300 preschool children and their families, the same number of children as were enrolled in fiscal year 1982.
>
> For the Administration on Aging, a level of $652,158,000 is requested to provide a full range of social and nutrition services to approximately 3.2 million elderly persons. This request includes a proposed transfer to the Aging program of the Department of Agriculture administered food commodities program for the elderly. This transfer will simplify program administration at both Federal and State levels.

In 1983, the Administration is proposing to transfer the Department of Education's Rehabilitation Services programs to the Office of Human Development Services. Within the Services to Selected Groups appropriation a total of $706,730,000 is requested for Rehabilitation Services and Special Institutions which include the American Printing House for the Blind, the National Technical Institute for the Deaf, and Gallaudet College. In 1983 Rehabilitation Services activities will be supported at a level of $623,509,000. The proposed consolidation of special purpose activities will provide greater State flexibility and simplify Federal regulations and oversight responsibilities. The Rehabilitation Services programs will be discussed in detail when the Department of Education testifies before the Congressional appropriations subcommittees.

For Developmental Disabilities State Grants and Advocacy, a level of $31,977,000 is requested. The program will continue to coordinate, monitor, and evaluate services provided to the developmentally disabled and to provide for systems of protection and advocacy of individual rights of persons who are developmentally disabled. We will continue the most productive special projects and university affiliated facility projects under the Human Resources Research and Demonstration appropriation.

For Native American programs, $23,282,000 is requested. The request will provide support to improve the quality of life for Native Americans and to improve management capabilities of Indian tribes and organizations. We expect to make grants to 135 tribal and other Native American organizations under this 1983 request.

An amount of $65,089,000 is requested for Human Development Services Federal Administration and $13,269,000 is requested for Rehabilitation Services Federal Administration. These funds will provide effective and efficient management of all programs administered by the Office of Human Development Services.

A level of $57,291,000 is requested for the new Human Resources Research and Demonstration appropriation. Of this amount, $26,491,000 will support the National Institute of Handicapped Research which the Administration proposes to transfer from the Department of Education. This program will be discussed in detail when the Department of Education testifies before the Congressional appropriation subcommittees. The balance of $30,800,000 will support research, demonstration, training, technical assistance and evaluations in the areas of child welfare, day care, youth, child and family development, child abuse and neglect, improving services to the developmentally disabled, and cross-cutting research, including technology transfer.

We are also recommending $380,120,000 and new substantive legislative changes in order to finance a new Child Welfare Block Grant appropriation. The request proposes to consolidate major children's services authorities, including: Child Welfare Services, Child Welfare Training, Foster Care, and Adoption

Assistance, into a single, flexible block grant to the States. The burden of cumbersome Federal regulations will be reduced while criteria for sound program mamagement will be maintained. This request is based on the assumption that Congress will enact the required enabling legislation prior to the enactment of 1983 appropriations.

Thank you, Mr. Chairman. My colleagues and I will be happy to answer any questions you and the committee may have.

BIOGRAPHICAL SKETCH

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Present: Assistant Secretary, Office of Human Development Services
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QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

COMMUNITY SERVICES BLOCK GRANT DISCRETIONARY FUND

Question: Under the Continuing Resolution, the Office of Community Services was directed to spend $31.3 million for 4 programs authorized under the Secretary's Discretionary Fund. To date, plans have been announced to spend only $5 million.

Can funds still be shifted, within the $348 million Continuing Resolution level, to provide $31.3 million for Community Service Discretionary activities--or will a supplemental be necessary to prevent reclaiming funds already distributed to the States?

Answer: A reapportionment of funds have been approved by the Office of Management and Budget for approximately $31 million for Office of Community Services (OCS) discretionary activities. A supplemental is not necessary since current grant awards to States have been made only through March 31, 1982 as specified under the terms of the Third Continuing Resolution. However, third and fourth quarter allotments to States will be reduced by the amount expended for discretionary programs.

Question: Specifically, how would the $5 million be utilized that you have so far agreed to spend for discretionary activities?

Answer: A final program plan has not been completed as of this date, but consideration is being given to ongoing activities of national and regional significance in such areas as rural housing, national youth sports and community economic development

LAWSUITS BY COMMUNITY SERVICES ADMINISTRATION EMPLOYEES

Question: What is the current status of the lawsuit filed against the Department of Health and Human Services by the former employees of the Community Services Administration?

Answer: Appeals by former employees of the Community Services Administration are currently before the Merit Systems Protection Board in the Office of Personnel Management. The Board is consolidating action on approximately 300 appeals. No hearings have yet been scheduled because former CSA employees have been given until the end of March to file their appeals with the Board.

Question: How many former Community Services Administration employees have you hired as a result of the lawsuit filed against the Department of Health and Human Services? Are these permanent or temporary jobs?

Answer: The lawsuit required that CSA employees be given permanent appointments in areas determined to be a transfer of function. To date 150 CSA employees have been given permanent appointments and approximately 51 temporary appointments.

Question: What are the implications of the lawsuit for plans to dismantle other Federal agencies such as the Departments of Education or Energy?

Answer: There are no implications. Lawsuits or the lack of lawsuits when agencies are dismantled will depend on the circumstances that exist at the time.

MONITORING COMMUNITY SERVICES BLOCK GRANT

Question: Are the reporting and auditing requirements in the Community Services Block Grant legislation adequate to ensure proper use of Federal funds and to provide Congress and the Administration with information about how funds are being spent?

Answer: Each State requesting direct funding must annually submit an application consisting of assurances, a plan, and a pre-expenditure report. Also, an independent audit of the State program must be made every two years. We believe this process will be adequate to assure fiscal accountability.

Question: During the year of transition in to the Community Services Block Grant (FY 82), how many employees will be needed to administer the program?

Answer: A total of 153 Full Time Equivalent (FTEs) positions are needed for administration of transition to the block grant program.

Question: After the transition year is over, how many employees will the Department of Health and Human Services need to administer the block grant?

Answer: The number of staff required to administer the block grant program in FY 1983 is 55 full-time employees including staff to administer and close-out discretionary awards made in 1982.

Question: Will all these employees be housed in the Office of Community Services?

Answer: The 55 employees will be located in Washington, D.C. within the Office of Community Services.

IMPACT OF CUTS ON COMMUNITY ACTION AGENCIES

Question: What has been the impact of the new block grant and accompanying budget cuts on the nationwide network of community action agencies?

Have any community action agencies closed down as a result of the block grant and budget cuts?

Answer: Community action agencies (CAAs) have been successful in accessing States, local governments and private sources. It is known, for example, that three-fourths of their resources already come from agencies other than, the former Community Services Administration. CAAs have been examining their programs for purposes of developing new approaches and establishing direct partnerships with the private sector. It is not known, at this time, whether any community action agencies have been closed down.

STATE ADMINISTRATION OF COMMUNITY SERVICES BLOCK GRANT

Question: How many States have opted to take over the block grant during FY 1982? Will all States be ready to take over the block grant in FY 1983?

Answer: On January 1, 1981, 40 States (including the District of Columbia), Puerto Rico and five territories opted for block grants. The balance of 11 were designated as transition States. Three States, Connectivut, New Hampshire and Montana began administering block grants in January 1982. The States of Maryland and New York have expressed their intent to assume responsibility for the Community Services Block Grant (CSBG) effective April 1, 1982. All States are anticipated to administer block grants in FY 1983.

Question: In States which are administering their own block grant programs, to what extent are former Community Services Administration grantees being refunded?

Answer: For FY 1982, the Community Services Block Grant Act includes a provision that States had to expend at least 90 percent of block grant funds on eligible grantees defined as follows:

- Organizations designated as Community Action Agencies (CAAs) in FY 1981.

- Limited Purpose Agencies (LPAs) which served the general purpose of a CAA or received funds under Section 222(a) (4) of the Economic Opportunity Act of 1964, as amended.

- Organizations serving migrant and seasonal farmworkers.

Question: What changes, if any, are States making in the types of grantees being funded under the block grant?

Answer: Preliminary indications are that not many changes are taking place due to the restrictions placed on States in FY 1982 as described above.

Question: How much are States spending for administrative expenses associated with the block grant, and what steps are being taken to control State administrative costs?

Answer: Section 675 of the Community Services Act states that a State will not expend more than 5 percent of its allotment for administrative expenses at the State level.

Question: Does the Department believe it would prevail if a lawsuit against it were brought, either a new impoundment case or action to enforce the existing court order?

Answer: The Department does not believe an impoundment has occurred in regard to the Rural Defense Loan Fund (RDLF). We can not foresee what the result would be if a lawsuit were brought against it. In addition, the Department does not believe it is legally bound to the existing court order brought against the Community Services Administration.

Question: Is the Department considering any alternative uses of the existing budget authority? If so, what?

Answer: Other than transferring $9 million in 1983 to the Community Services Block Grant, the Department is not considering any further reprogramming at this time.

CUTS IN SOCIAL SERVICES

According to the Press, a study by the National Association of Social Workers estimates your fiscal 1983 budget requests will eliminate social services, such as Day Care and Homemaker Aid, for more than 3 million people. Your fiscal 1983 budget justification conspicuously lacks any estimate of service levels to be provided in either fiscal 1982 or fiscal 1983.

Question: Can you tell us whether the press report is accurate, that the 1981 level of 7.7 million people receiving Social Services will decline to 4.4 million recipients in fiscal 1983?

Answer: The National Association of Social Worker's study appears to have used a straight-line methodology of reduced dollars plus the inflation impact to project a reduction in the number of people that will receive services. This methodology at best would provide a very gross estimate. The study also uses estimated primary recipients, 7.7 million, for the projection of people to receive services. The total number of persons receiving services in FY 1981 was in excess of 10 million people. Thus the use of primary recipient data is misleading. For example, assume a working mother with two children receiving child day care, the mother is the primary recipient but not the two children. Also, straight-line methodology assumes the same mixture of eligibility requirements, recipients, and services which is not necessarily correct. Even with the time limitations of the first year, States have made the following types of changes to their programs in FY 1982:

- prioritizing services and dropping less effective and less vital services
- targeting eligibility on those most in need of services
- using other Federal funds for services, Aid to Families with Dependent Children for day care and Medicaid for family planning
- increasing user fees based on ability to pay part of the cost
- transferring other Block Grant funds to the Social Services Block Grant
- reducing administrative cost under the Social Services Block Grant

Question: Is it going to be standard practice that your budget justification material to Congress for Block Grant programs will not contain estimates of service levels so that Congress will have difficulty judging the impact of requested funding?

Answer: There is no legislative authority for requiring statistical reporting under the Block Grant. The only requirements for Block Grants are the pre-expenditure report, the post-expenditure report and the audit report. The post-expenditure report and the audit report will be submitted by the State not less often then every two years. The Department is working with the American Public Welfare Association and State representatives to establish a voluntary system for reporting that would provide workload data. Until we can get such a system established there will be very little workload data available.

UNPRODUCTIVE PROJECTS IN HUMAN SERVICES BLOCK GRANT

You indicate in your prepared statement that the recommended budget cuts in the Human Services Block Grant will give States the opportunitiy to eliminate "unproductive projects".

Question: How many "unproductive projects" do you estimate are currently being funded?

Answer: The term "unproductive projects or programs" is probably an erroneous description. What we meant was less effective programs that are actually of less priority. States have been making changes by prioritizing services and dropping those that are less effective nd the less vital services. We do not know the number of services that have been affected. However, we do know that such States as Alabama, Arizona, Arkansas, District of Columbia, Hawaii, Indiana, Kentucky, Massachusetts, Mississippi and South Dakota have been involved in such as effort.

Question: What types of projects are being eliminated in Fiscal 1982, when Congress cut the appropriation from 2.9 billion down to $2.4 billion?

Answer: For some States all services have been maintained while in other States certain services have been dropped. Some of the types of services that have been deleted or reduced in some States, in FY 1982, are legal services, transportation services to pregnate adolescents, services to foster grandparents, companionships, counselling services, family counselling, meals on wheels, and service to the developmentally disabled. The funding of certain services have been shifted to other programs. For example, rather than using Social Services Block Grant funding, Aid to Families with Dependent Children resources are used for day care and Medicaid for family planning.

Question: What evidence is there from the States that effective projects serving those most in need are actually being curtailed?

Answer: The information we have received from the States indicated that they are being very careful in their program reductions. Every effort is being made to continue the most effective services and to target them on those most in need.

SOCIAL SERVICES TRAINING

Question: Now that training is no longer a separately authorized activity under title XX to what extent are States using their block grant funds to provide training to State and local social services personnel?

Answer: We do not have very much data on FY 1982 training activities, but it is our impression that a number of the States have significantly reduced their training and staff development programs under the Social Services Block Grant and the earlier reductions in training resources.

REPORTING UNDER SOCIAL SERVICES BLOCK GRANT

Question: Are there sufficient reporting and auditing requirements in the new Social Services Block Grant legislation to provide the Federal Government with timely and accurate information on how Federal funds are being spent?

Answer: It is believed that the requirements are adequate given that the responsibility for the management of the resources rests with the States. The pre-expenditure and post-expenditure reports and the voluntary statistical reports will presumably provide the necessary information on how Federal funds are being spent for Federal purposes. However, it should be pointed out that the statute provides that the audit reports and the post-expenditure reports be submitted every two years.

CHANGES IN SOCIAL SERVICES BLOCK GRANT

Question: Based on the reports States are required to develop on their intended use of Social Services Block Grant funds, how are States changing their programs as a result of the Reconciliation Act?

Answer: States had a very short time period between the enactment of the law and the implementation date of the Social Services Block Grant. Surprisingly, a number of changes have been initiated by the States including:

- prioritizing services dropping less effective and less vital services
- targeting eligibility on those most in need of services
- increasing State and private support of certain services
- using other Federal funds for services
- increasing user fees based on ability to pay part of the cost
- transferring of other block grant funds to the Social Services Block Grant
- reducing administrative costs under the Social Services Block Grant

Question: Now that the States are no longer required to spend Title XX funds only on the poor and near-poor, have they expanded the population group eligible for services?

Answer: What information we have on eligibility under the block grant indicates a tightening of requirements. To be eligible, families have to be at lower income levels. Certain services are now limited to Aid to Families with Dependent Children and Supplemental Security Income recipients. As in the past, certain services continue to be available on a universal basis, but in terms of the total population served, the poor and near poor may well represent a greater proportion of the population receiving services.

Question: What has been the impact of the Reconciliation Act on groups which formerly were guaranteed a minimum amount of Title XX services, such as supplemental security income recipients?

Answer: The group previously guaranteed a minimum amount of Title XX resources were the public assistance recipients (i.e. Aid to Families with Dependent Children and Supplemental Security Income). With the apparent trend in tightening financial eligbility it would not be surprising if the same or greater proportion of Title XX resources were devoted to that group.

Question: What has been the impact of budget reductions in Title XX on States? Are States providing fewer services, serving fewer people, charging fees for services?

Answer: The impact of the budget reduction has been that fewer people will receive service, some services may be eliminated and a number of States have increased the fees that they charge based on ability to pay part of the cost of services. Some States have also shifted the method of financing services such as charging Aid to Families with Dependent Children for day care and Medicaid for family planning. Some States have also transferred funds from other Block Grants to Title XX.

TRANSFER OF SOCIAL SERVICES BLOCK GRANT FUNDS

Question: To what extent are States transferring Social Services Block Grants Funds for use under the Health or Energy Assistance Block Grant?

Answer: According to a recent survey by the National Governors Association twenty States elected to transfer funds to their Social Services Block Grant from other Block Grants. The survey indicates that only one State transferred funds from their Social Services Block Grant. All of the transfers to the Social Services Block Grant were made for the purpose of continuing essential social services to citizens. The Social Services Block Grant attracts transfers in because of the wide latitude and flexibility afforded States under that particular block grant.

STATE MATCHING FUNDS FOR SOCIAL SERVICES

Question: Now that States are no longer required to furnish a non-Federal share to receive title XX funds, to what extent are State, local or private funds now available for Social Services programs?

Answer: We do not have claiming or reporting requirements that provide this type of information. Even when the States were required to provide a matching amount it was difficult to determine the total non-Federal funds utilized. Most States reported only the amount that was required to receive the Federal funds plus a limited additional amount to be utilized in case particular cost areas were disallowed. While there are indications that some States reduced the non-Federal match, there are reported instances of States increasing their funding to compensate for the reduction in Federal funds.

BLOCK GRANT EVALUATION STUDY

Question: What is the status of the mandated study required by the Reconciliation Act on ways states can evaluate their block grant programs?

Answer: The mandated study was begun in September 1981 and is well underway. The study is being conducted in three phases. Phase I (Review of Existing Literature and Design of Field Study) was completed in December 1981. Phase II (Field Study of Evaluation Measures and Practices) will be completed in seven states (Maine, Florida, Iowa, Wisconsin, Colorado, Washington, Texas) by the end of March 1982. Phase III (Study Report) will be completed in draft by June 1982. After Departmental clearance, the study report will be sent to Congress.

Question: Will this study be available to Congress by the statutory deadline of July 1982?

Answer: Yes, the study will be available to Congress by the statutory deadline, August 13, 1982.

RESEARCH AND DEMONSTRATIONS

Question: What are the Fiscal Year 1983 funding priority areas for the Child Welfare Research and Demonstration Program?

Answer: Funding priorities in Fiscal Year 1983 will continue to focus on Child Welfare Service Delivery Practices and the development of models to improve those practices. Specific emphasis will be placed on increasing adoption opportunities, and reducing the numbers of children in foster care. In these areas there will continue to be a focus on children with special needs. In addition, efforts will continue in finding alternative ways to improve day care and to demonstrate quality day care practices.

Other priority areas will be contingent upon the expressed concerns of Federal, State and local agencies during the planning phase of fical year '83 discretionary program activities.

Question: How are these priorities determined?

Answer: Priority needs are established through the active participation of Federal, State and local agencies in the HDS planning process.

In 1981 over 3,000 letters were mailed to representatives of the Public and Private sector, colleges and universities, national organizations and Federal agencies. These organizations examined the need for priority areas listed in the "Dear Colleague" letter and put them in rank order, and/ or suggested additional areas. Additional areas identified in their responses were given careful consideration with respect to HDS discretionary allocations. In 1982 the process will be further strengthened through national research and demonstration planning conferences involving national organizations, State and local grantees and other concerned individuals.

Question: If the Child Welfare Research and Demonstration Program is consolidated into a broader research "block" how will research priorities be determined?

Answer: Research priorities will continue to be determined based on the priority needs identified by Federal, State and local agencies solicited during HDS' planning process and those of HDS Executive staff.

Question: If the Child Welfare Research and Demonstration Program is retained as a categorical program, will there be any provision for State or local input into funding decisions?

Answer: Provision for state and local input into funding decisions was established as part of the HDS planning process in 1981. Federal, State and local agencies will continue as active participants in this process, as they have in the past.

Question: If the Child Welfare Research and Demonstration Program is consolidated with other social services-related research programs, what guarantee is there that child-and-family related projects will continue to be supported?

Answer: If the Child Welfare Research and Demonstration program is consolidated with other research programs, discretionary activities under this category will continue to be supported as they have previously.

Child and family related research issues will remain as a high priority for HDS since these issues cut across all HDS programs. In planning the HDS research agenda for child welfare, appropriate national organizations, child welfare administrators and concerned individuals will be consulted in setting priorities.

In some cases, support for individual activities will be strengthened as we acquire increased flexibility and proficiency through eliminating duplication of effort and producing more effective and efficient planning strategies.

Question: Are there any plans for prorating support of projects according to the funding patterns of the original categorical programs?

Answer: Based on our experience with the 1982 Research and Demonstration Program Announcement, it is expected that all future categorical priority areas will be adequately addressed in the grant applications. Decisions to fund each priority area depends upon the level of interest expressed by program officials, and those outside individuals and organizations providing input in the process. In addition, both legislation and congressional intent are carefully considered in allocating funds to each priority areas.

Based on these factors, it is assumed that the consolidated discretionary authority would not result in a significant change in the broad patterns of funding. However, greater efficiency of funding would be accomplished by eliminating duplication and overlap of projects.

Question: No legislative authority exists for the Administration's request to consolidate Child Welfare Research, Child Abuse Projects, Other Research, and Adoption Opportunities, DD Special Projects, and DD-UAF's into the "Social Service Discretionary Activities Program." Clearly, submitting language to the Labor - HHS - Education Appropriations bill is not sufficient. Therefore, your proposal is contingent upon a formal request for changes in current legislation. When will you be submitting such language to the appropriate authorizing committee?

Answer: HDS is making its appropriations request for Social Services Discretionary Activities against a group of existing legislative authorities rather than on a line-by-line basis. No repeals or modifications of existing legislative authorities is being requested. HDS will not ask for changes in current authorizing legislation because no such changes are necessary.

IMPACT OF LAYOFFS AND STAFF REASSIGNMENTS

Question: How serious an impact have staffing cuts, downgradings, and "bumping" of remaining staff into unfamiliar job assignments had on the effectiveness of Federal program administration?

Answer: I believe that the effectiveness of Federal program administration has not been adversely affected as a result of the reduction in force.

Question: From which programs will the additional 36 positions to be eliminated in fiscal 1983 be taken?

Answer: As a result of the reduction in force the current employment ceiling for the Office of Human Development Services is 1,260. Therefore, it will not be necessary to further reduce any of the program personnel ceilings in 1983.

Question: If Congress fails to enact the proposed consolidation of several categorical programs into Block Grants, how many Federal staff, over the existing budget request, would be needed to maintain current activities?

Answer: No positions would have to be added in order to maintain current activities.

STAFF CUTS FOR FEDERAL ADMINISTRATION OF AGING PROGRAMS

Question: What effect will the Reductions In Force (RIFs) planned for the Administration on Aging have on Federal responsibilities for oversight of State Agency Administration of the Older Americans Act?

Answer: While the Administration on Aging has experienced the reassignment of some employees, it is expected that Federal responsibilities will be carried out with a minimum of disruption due to personnel changes. The Administration on Aging held orientation sessions for all new and reassigned personnel in order to facilitate an orderly transition.

Question: How many staff will be cut from the Administration on Aging -- at the Federal Central and Regional office levels?

Answer: AoA had many unencumbered positions when the RIF began, the number of filled positions abolished was 3 at Central office and another 3 in the regions. Although 31 AoA employees were ultimately affected by the entire RIF process at HDS the total number of AoA employees actually separated from OHDS was only 12.

FEDERAL COUNCIL ON AGING

Question: In view of the budget reductions required for the Federal Council on Aging, will it be possible for the Council to conduct its legislative responsibilities in advising the President, and its other activities, such as conducting its required meetings?

Answer: It is possible for the Council to conduct its legislative responsibilities inspite of the budget reduction.

Question: What level of staff will be supported by the $175,000 proposed budget?

Answer: The proposed budget will support a staff of two, one professional and a secretrary.

Question: Should Council activities be phased down completely for a year, given its budget contraints?

Answer: It would not be necessary to completely phase down the Council activities given its budget constraints. Its advisory role will be maintained and resources from other agencies could be generated in the event the Council decides to undertake certain special projects within its legislative mandate.

Question: Since the White House Conference has recently taken place and given that it also has responsibilities to advise the President on policies in the field of aging, can its recommendations be substituted for Federal Council advice during FY 1983?

Answer: The White House Conference on Aging will be phased out after it has submitted its report and recommendations to the President and that will occur in FY 1982. The Federal Council can provide the follow-up activities necessary to ensure continuity of purpose.

WORK INCENTIVE PROGRAM (WIN)

Senator Dixon has introduced Senate Resolution 325, which has been referred to the Appropriations Committee, seeking a $76.8 million supplemental for the Work Incentive Program.

Question: How is the $245.8 million continuing resolution level for the WIN program being used and what would be the impact of restoring $76.8 million?

Answer: Of the $245.8 million under the latest continuing resolution for WIN, $43.8 million is currently planned for use in the WIN Demonstration Program in 20 States; $188.0 million for the operation of the regular WIN program; and $14.0 million for program direction and evaluation. In both the regular WIN and the WIN Demonstration Program, States have, by law, considerable flexibility as to how the funds are utilized.

If $76.8 million in WIN funding were to be restored in fiscal year 1982, 2,000 to 2,200 State welfare and employment service staff could be restored. However, because States have already been cutting back operations under the latest continuing resolution, this would require a rapid buildup to expand the funds in this fiscal year, only to be followed again by phase-down and close-out in fiscal 1983, as proposed by the Administration. These repeated shifts in program funding levels would create serious inefficiencies.

Question: Do you agree with Senator Dixon's figures that the $365.0 million WIN program in fiscal 1981 saved $760.0 million in welfare payments--more than twice its cost?

Answer: In fiscal year 1981, more than 310,000 WIN registrants entered unsubsidized employment, resulting in estimated annualized welfare grant reductions of approximately $760.0 million. It should be noted that WIN employment is only "counted" for 30 days; therfore it is not possible to determine the actual realized savings nor to what extent estimated or actual reductions are directly attributed to WIN.

BLOCK GRANT

Question: What is the rationale for consolidating the WIN program with the Human Services Block Grant, as you propose in the fiscal 1983 Budget?

Answer: The revised appropriation language in the Human Services Block Grant was requested to give States the option to continue WIN-type activities in fiscal 1983. In addition, such activities may also be carried out under the proposed employment and training block grant and the Community Work Experience Program (CWEP), which the Administration is proposing to make mandatory for all States.

WIN PROGRAM/CETA

Question: How do the services provided under the Work Incentive Program differ from services provided through the Comprehensive Employment and Training Act?

Answer: The WIN program contains a work requirement, including adjudication and related activities, which is not provided for in CETA. Otherwise, both provide for similar kinds of services.

Question: How do the population groups differ in these two programs?

Answer: WIN serves exclusively a welfare population whereas CETA has been serving a wide variety of clients. Of the WIN registrants, theree-fourths are women, and over half have not graduated from high school.

Approximately on-fourth of CETA participants are on welfare and over half have at least a high school diploma. It should be noted that the proposed employment and training block grant would concentrate services on welfare recipients and youth.

WORKFARE

Question: What is the Department of Labor's role in the new workfare program authorized for Aid to Families with Dependent Children recipients by the Reconciliation Act?

Answer: The Community Work Experience Program (CWEP) and the Work Supplementation Program (WSP) are administered by the Office of Family Assistance in the Social Security Administration, HHS.

The Department of Labor would continue to support employment and training services to welfare recipients under the new proposed employment and training block grant, as well as through the Job Service.

Question: What has been learned through the WIN program that might be useful in future debates concerning workfare?

Answer: The WIN program has demonstrated the validity of a work requirement, and the effectiveness of structured job search, employment and training services, and appropriate social support services in promoting economic self-sufficiency for welfare recipients through unsubsidized private sector employment.

SUPPORTIVE SERVICES

Question: What has been learned during the years of administering WIN about the importance of supportive services such as Day Care?

Answer: The WIN experience has clearly shown that supportive services such as day care are an adjunct to employment and training services in order to assist welfare recipients, many of whom are single parents with children, in becoming self-sufficient through employment. A recent research study found that the most productive WIN projects were particularly proficient at coordinating social and employment-training services.

Question: What effect will reduction in these services, through budget cuts in Win and Title XX of the Social Security Act, have on people's ability and incentive to work?

Answer: The Administration's proposal provides States the option of continuing WIN-type activities and services under other legislative authorities and alternative funding sources. We are confident that States will use these resources where the return on investment will be greatest and to meet the needds of the most needy.

WIN DEMONSTRATION PROGRAM

Question: What is the legal status of the 1981 Reconciliation Act provision which indicates States electing to operate newly authorized demonstration programs would not receive budget cuts?

Answer: The language in the Omnibus Budget Reconciliation Act of 1981 with respect to funding for the WIN Demonstration Program constituted a budget authorization not an appropriation. As with other programs, the actual funding for both the regular WIN program and the WIN Demonstration Program is subject to the congressional appropriations process. Both regular WIN and the WIN Demonstration Program share in any reduction in the WIN appropriation, which is the source of funds for both.

Question: Which States have elected to operate such a demonstration program?

Answer: Initially, within the legally specified period, 26 States submitted applications to operate a WIN Demonstration Program. Subsequently, 6 States have withdrawn and the 20 States remaining are:

Arizona
Arkansas
Delaware
Florida
Illinois
Maine
Maryland
Massachusetts
Michigan
Nebraska
New Jersey
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Dakota
Texas
Vermont
Virginia
West Virginia

STAFF

Question: Provide for the record a State-by-State list of WIN staff, for fiscal 1981, compared to the fiscal 1982 continuing resolution level. Indicate a break-out of staff assigned to Job Service offices, as well as State Welfare offices.

Answer: Table 1 provides a State-by-State listing of WIN staff, including separate break-outs for Job Service staff (ETU) and welfare staff (SAU), for fiscal 1981 and the first quarter of fiscal 1982. The staffing effects of the one-third funding reduction under the latest continuing resolution, however, are not reflected in the first quarter figures. Since that reduction occurred on December 15, staff cuts were not made until sometime during the second quarter, and will not be reported until May or June. Preliminary indications are that staffing reductions will be at least one-third and possibly greater.

Question: How would a $76.8 million fiscal 1982 supplemental be divided among the States, and how many staff would it provide?

Answer: The $76.8 million restoration would increase individual State allocations by approximately 33 percent. (See Table 2.) This would apply to both the regular WIN and the WIN Demonstration States. Approximately 2,000 to 2,200 employment service and social service staff could be retained to enforce the work requirement and assist eligible WIN registrants find unsubsidized employment.

Question: How many separate WIN units are there in local job service offices, and how many WIN staff are simply integrated with regular local employment service staff?

Answer: In the 1979 directory, there were 374 separate WIN local offices and 790 offices that are combined with Job Service offices. However, this does not mean that staff are integrated. Each staff performs those activities authorized by their program funding source. This is tracked by the State Employment Security Agency (SESA) cost accounting system (CAS).

SUPPLEMENTAL

Question: Given the near-record rates of unemployment, with no improvement in sight, does the Administration plan to request a supplemental appropriation for the remainder of fiscal 1982? If so, when? If not, for what reason?

Answer: The Administration does not plan to request a supplemental appropriation for WIN for the remainder of fiscal 1982, because the current funding level under the latest continuing resolution is consistent with the Administration's proposal to phase-out the WIN program in fiscal 1983 with no funding authority provided. States have already begun to phase down their WIN programs under the current funding level.

WIN PROGRAM

Question: Given the proven and impressive cost effectiveness of the program and its success in furthering many of the Administration's goals, why has the WIN program been proposed for elimination in fiscal 1983?

Answer: Under the Administration proposals, States have the option of continuing WIN-type functions, activities and services under other authorizing legislation and alternative funding sources. Chief among these is the Community Work Experience Program (CWEP), which the Administration is proposing be made mandatory for all States, and which would be funded under Title IV-A of the Social Security Act. Other potential sources of funding are the human services block grant, the new proposed employment and training block grant, the community service block grant, and rehabilitation services funds. This approach is consistent with the Administration's New Federalism policy.

Total Staff (person years paid)
for
ETU and SAU
Fiscal Year 1981 and 1982

	FY 1981			First Quarter FY 1982		
State	Total Staff	ETU Staff	SAU Staff	Total Staff	ETU Staff	SAU Staff
Alabama	116	79	37	112	75	37
Alaska	24	15	9	23	13	10
Arizona	94	66	28	78	51	27
Arkansas	99	74	25	105	63	42
California	1,370	1,031	339	1,220	878	342
Colorado	158	113	45	146	101	45
Connecticut	181	121	60	161	101	60
Delaware	43	31	12	40	30	10
Dist. of Col.	112	75	37	99	62	37
Florida	226	141	85	221	136	85
Georgia	245	180	65	205	140	65*

	FY 1981			First Quarter FY 1982		
	Total Staff	ETU Staff	SAU Staff	Total Staff	ETU Staff	SAU Staff
Guam	33	7	26	33	7	26*
Hawaii	61	45	16	62	47	15
Idaho	87	61	26	85	58	27
Illinois	587	424	163	549	415	134
Indiana	165	113	52	146	94	52
Iowa	123	67	56	115	59	56
Kansas	130	74	56	106	78	28
Kentucky	166	112	54	148	99	49
Louisiana	136	74	62	117	70	47
Maine	81	58	23	83	59	24
Maryland	288	205	83	264	181	83
Massachusetts	460	327	133	434	301	133
Michigan	615	467	148	512	364	148
Minnesota	213	146	67	188	154	34
Mississippi	143	80	63	123	65	58
Missouri	271	160	111	243	148	95
Montana	43	33	10	43	27	16
Nebraska	51	31	20	48	30	18
Nevada	26	21	5	26	21	5*
New Hampshire	36	17	19	33	17	16
New Jersey	401	263	138	374	253	121
New Mexico	69	49	20	65	45	20
New York	874	655	219	800	579	221
North Carolina	219	111	108	198	120	78
North Dakota	36	22	14	26	15	11
Ohio	692	450	242	669	432	237
Oklahoma	73	52	21	46	40	6
Oregon	243	193	50	234	186	48
Pennsylvania	483	353	130	504	388	116
Puerto Rico	195	60	135	190	55	135*
Rhode Island	89	48	41	84	41	43
South Carolina	171	88	83	166	83	83*
South Dakota	43	27	16	34	22	12
Tennessee	146	114	32	165	121	44*
Texas	321	201	120	293	175	118
Utah	108	65	43	90	51	39
Vermont	113	74	39	115	76	39
Virginia	246	170	76	247	151	96
Virgin Islands	13	7	6	14	8	6*
Washington	359	257	102	380	258	122
West Virginia	191	137	54	186	132	54
Wisconsin	402	289	113	383	270	113
Wyoming	18	15	3	13	10	3
Total	11,888	8,148	3,742	11,044	7,455	3,589

*No December report - using September 1981 data.

Work Incentives

Pg.1 of 2 Pgs.

GRANTS TO STATES 1/

Actual and Estimated Awards for Work Incentive Program Employment and Training Activities and Social Services

Fiscal Years 1981-1982

TABLE 2

State	1981 1/	1982 Revised Estimate 2/	1982 Supplemental
Alabama	3,265,709	2,157,744	716,063
Alaska	1,085,922	806,708	267,697
Arizona	2,462,002	1,384,019*	558,371
Arkansas	2,104,067	1,275,703*	423,329
California	48,466,466	30,350,094	10,353,315
Colorado	5,931,981	3,749,167	1,289,304
Connecticut	5,021,664	3,200,743	1,121,953
Delaware	1,174,413	779,577*	258,694
Dist. of Col.	3,500,803	2,191,686	727,287
Florida	5,253,639	3,382,483*	1,225,021
Georgia	5,818,685	3,494,643	1,159,660
Guam	260,000	173,290	57,505
Hawaii	1,932,005	1,368,657	454,174
Idaho	2,370,127	1,731,214	574,485
Illinois	17,186,676	11,355,868*	3,768,319
Indiana	4,495,044	3,100,282	990,327
Iowa	3,462,059	2,386,001	791,768
Kansas	2,707,905	1,715,838	569,382
Kentucky	3,601,046	2,346,621	795,729
Louisiana	2,835,389	1,707,129	566,490
Maine	2,011,088	1,238,632*	455,678
Maryland	6,408,099	4,300,583*	1,407,037
Massachusetts	11,066,647	7,647,113*	2,534,504
Michigan	25,544,329	15,381,134*	5,675,181
Minnesota	6,501,302	4,547,667	1,568,973
Mississippi	3,052,411	1,775,408	619,335
Missouri	5,586,502	3,159,391	1,116,294
Montana	1,556,138	1,035,647	343,669
Nebraska	1,227,892	776,714*	257,357
Nevada	1,030,754	677,753	224,905
New Hampshire	768,759	481,806	159,881
New Jersey	13,693,180	8,442,987*	2,801,711
New Mexico	1,595,488	971,606	322,416
New York	28,526,947	19,924,373	6,611,683
North Carolina	4,847,948	3,311,819	1,098,991
North Dakota	963,018	534,556	205,069

Actual and Estimated Awards for Work Incentive Program Employment and Training Activities and Social Services (continued)

TABLE 2

State	1981 1/	1982 Revised Estimate 2/	1982 Supplemental
Ohio	19,641,596	12,829,050	4,257,178
Oklahoma	2,097,570	1,381,281*	458,364
Oregon	9,671,995	6,199,603*	2,057,270
Pennsylvania	15,729,937	10,368,292*	3,420,293
Puerto Rico	2,556,841	1,408,554	467,413
Rhode Island	2,031,103	1,284,217*	453,483
South Carolina	2,854,262	1,672,511	555,003
South Dakota	1,495,491	986,837*	327,472
Tennessee	3,477,271	2,258,342	749,405
Texas	8,934,651	4,710,051*	1,562,978
Utah	4,853,373	2,724,438	1,016,489
Vermont	2,481,199	1,710,623*	580,690
Virginia	4,998,382	3,266,094*	1,083,048
Virgin Islands	370,192	200,702	66,602
Washington	12,290,390	9,658,540	3,205,079
West Virginia	4,790,444	3,387,483*	1,224,789
Wisconsin	13,776,676	8,369,710	3,114,221
Wyoming	592,523	370,586	128,666
Grants	349,960,000	225,651,600	76,800,000
Postage	1,000,000	1,000,000	0
	350,960,000	226,651,600	76,800,000
Reserve	0	5,108,400 3/	0
Total	$350,960,000	$231,760,000	$ 76,800,000

*Planned WIN Demonstration States' funding included.

1/ New budget authority issued to Employment and Training Units, and limits of entitlement issued for the Separate Administrative Units.

2/ Distribution of new budget authority based on the December 15, 1981 continuing resolution. Subject to modification during the fiscal year.

3/ National reserve to apply towards WIN closeout costs and changes in funding resulting from slippage in new WIN Demo start dates.

TRANSFER OF AGRICULTURE SURPLUS COMMODITIES PROGRAMS

Question: Your budget request recommends transferring the Department of Agriculture's surplus commodities program to your agency, merging it with your nutrition for the elderly program. What would be the impact of this proposal?

Answer: The proposal to transfer the Commodities or Cash-in-lieu-of Program from the Department of Agriculture to the Administration on Aging would have the following impact:

- o Currently the program does not require a non-Federal match. The intent is to require a 15 percent state match. In 1983 this would amount to $14,800,000.
- o The entitlements are currently based on the number of meals served. The proposal would based the entitlements on amounts received in FY 1982.
- o However, some cost savings are seen in the simplifying of states' program administration. States would have to deal with only one agency, the Administration on Aging. The burden of reporting quarterly to the Department of Agriculture on numbers of meals served in the previous quarter and estimated numbers for subsequent quarter would be eliminated.

The advantages resulting from the simplification of the program, in our opinion, outweigh other considerations. It should be noted that, on a national basis, states are exceeding the required match. Therefore, this additional match requirement should not be a significant burden.

NUTRITION

Question: In total, how many fewer elderly people would receive hot meals under your Fiscal 1983 budget request?

Answer: We cannot identify specific numbers of older persons affected by reductions or increases in funding. The funds appropriated in FY 1982 would support 677,163 meals per day. The funds requested in FY 1983 for Nutrition Services would support 607,845 meals per day, a reduction of 69,318 meals per day.

Question: How much would have to be added to the Fiscal 1983 budget to keep congregate and home-delivered meals at the fiscal 1982 level?

Answer: Technically an additional $32,280,000 would be required for Congregate Nutrition Services and an additional $10,352,000 for Home-delivered Nutrition Services. However, through an increase in contributions and administrative efficencies we would hope to reduce this amount significantly.

CONTRITUTIONS BY ELDERLY FOR SERVICES

Question: Under the Older Americans Act Regulations, service providers are required to give each older person receiving a service an opportunity to make voluntary contributions to cover the cost of the service and to use all contributions to expand the service base. Why shouldn't the Older Americans Act be amended to require mandatory contributions for services?

Answer: At this time, mandatory contritutions are not being considered because we believe that significant increases can be generated from increased voluntary contributions. As long as this is possible, we believe it is preferable to solicit voluntary contributions instead of imposing mandatory fees. While voluntary contributions have always been accepted and sometimes encouraged, there has never been a major effort to collect contributions. The Administration on Aging believes that through a planned effort to encourage contributions additional income can be generated.

Question: What means do you propose to increase the contributions older persons make toward the cost of services?

Answer: One of the strategies developed in order to maintain nutrition services to the extent possible is an increase in program income. Contributions by older persons are only a part of this program income.

Our plans call for an increase in program income of $41,000,000, from $79,000,000 in FY 1981 to $120,000,000 in FY 1983. The following activities are designed to increase contributions:

- o determining the past and current level of program income expenditures by area agencies, and analyzing state and area agency policies and procedures governing the use and accountability for such funds;
- o follow-up with state and area agencies to urge them to improve income accountablilly and expenditure for Title III services;
- o identification and dissemination regarding models of best practice for use by area agencies in generating program income; and
- o carrying out a national public information campaign which will indicate the benefits to be achieved from successfully managing this sizeable resource (public information materials to be developed and issued during FY 1982/83).

As part of an 18-month effort, there will be identification of areas such as models of best practice and information to be disseminated.

Question: What is the level of program contributions made by older persons toward the cost of social and nutrition services for the last three fiscal years?

Answer: As mentioned earlier, the Administration on Aging only has information on the program income expended by states which include, but are not limited to, contributions made by older persons. In addition to the program income reported by the states as part of their required non-federal match, states have reported the following program income expenditures for Supportive Services and Senior Centers, and Nutrition Services in recent years:

FY 1979	$39,821,000
FY 1980	$57,966,000
FY 1981	$67,930,000

Question: Is there any information available on the level of contributions by non-low income elderly?

Answer: The Administration on Aging collects information on program income expended by the States. Contributions made by older persons are only a part of the program income and are not reported separately. Therfore, we do not have information on the level of contributions made by non-low income elderly.

TRIMMING ADMINISTRATIVE COSTS IN AGING NUTRITION PROGRAMS

Question: What steps has the Administration on Aging taken to improve the management and efficiency of the nutrition program and to trim administrative costs of the program?

Answer: The Administration on Aging has been active in its efforts to improve program management and efficiency in the nutrition program and trim administrative costs of the program. Guidance has been provided through a number of program initiatives and information memoranda published by the Administration on Aging in recent years. This guidance offers some suggested approaches which will assist states to systematically establish target operating levels consistent with available resources. Regional offices have provided guidance to state and area agencies through periodic assessments of the program. These assessments cover established goals, resources available and used, targets established and accomplished, problems, issues, and overall management techniques.

An Operational Management System (OMS) initiative was created with the specific purpose of improving information management and organizational capacity of state and area agencies on aging in the nutrition program. Several demonstration projects concerned with building information management systems, and data collection and repoorting systems have been funded.

A major contract is underway to update nutrition services programs and financial management guides, and to provide training to state and local staffs for improving nutrition services management. A contract has also been awarded to develop a comprehensive financial management manual for area agencies, along with related tools to improve the monitoring and asessment of area agency and service provider financial management systems.

Question: What new steps can be taken to reduce the average cost per meal under the Older Americans Act Title III Nutrition Program?

Answer: The Administration on Aging will be taking steps to help providers improve both program and financial management which could help reduce the total meal cost.

LONG-TERM CARE DEMONSTRATION PROJECTS

Question: How much of the total Administration on Aging funding for the National Long-term Care Channeling Demonstration Program has been obligated and spent by grantees and contractors under the program?

Answer: Funds for the National Long-term Care Channeling Demonstration Programs were first made available in FY 1980. A total of $9,300,000 was awarded that year by the Administration on Aging for 15 State System Development projects, six Channeling Demonstration projects, and a contract to evaluate this program. These three elements are interrelated and consist of the following:

- o System Development provides for development of a Long-term Care (LTC) planning structure at the state level and of a LTC plan based on assessment of needs and resources;
- o Channeling Demonstrations include development of organizational structures and operating procedures at the community level to match resources with identified needs.
- o Evaluation of the program includes data collection and analysis of experimental and control groups to assess processes and outcomes of the demonstrations.

To date, the $2,400,000 awarded for the evaluation of the program in FY 1980 has been fully obligated and spent by the contractor. The 15 States awarded a total of $1,500,000 for the System Development projects have also obligated and spent all of their funds. This phase of the program ended by late February 1982.

The Administration on Aging awarded $5,400,000 in FY 1980 and $4,000,000 in FY 1981 for the Channeling Demonstrations. Current data on obligations and expenditures by the recipient states are not available at this time.

Question: What amount, and proportion of the total amount available, has been devoted to supporting technical assistance and evaluation activities under the National Long-term Care Channeling Demonstration Program?

Answer: Funds appropriated to the Administration on Aging have not been used to support technical assistance activities for the National Long-term Care Channeling Demonstration Program. Of the $13,300,000 awarded by the Administration on Aging ($9,300,000 in FY 1980, and $4,000,000 in FY 1981), $2,400,000 or eighteen percent was awarded for the evaluation of the program.

Question: How much, if any, of the funds already obligated has been used for testing service models in long term care, or are most projects still in the planning stages?

Answer: Four of the ten demonstrations have completed the planning phase of the projects and are testing service models. Six demonstrations are scheduled to complete the planning stage by April 1982. Current information on the amounts used for the testing of service models is not available, because the phase was initiated in February of 1982.

Question: If the National Long-term Care Channeling Demonstration Program is significantly reduced in Fiscal 1983, how much planning effort on the part of the grantees and contractors will have been lost?

Answer: Initially a total of 12 Long-term Care Channeling Demonstrations were funded for two years in FY 1980, six by the Administration on Aging and six by the Health Care Finance Administration (HCFA). In FY 1981, the option to refund two of the demonstrations was dropped; the Administration on Aging refunded four demonstrations for an additional two years and the Health Care Finance Administration funded one demonstration for an additional two years.

Current plans are for the Administration on Aging to fund one demonstration in FY 1983 for an additional two years. Demonstrations in four other states will be continued with funds from HCFA. The reduction in the number of demonstrations supported is consistent with the President's policy to reduce federal spending. Additional reductions in funding will result in loss of all efforts to date and would not provide a minimum basis of support for the programs.

NATIONAL CLEARINGHOUSE ON AGING

Question: If the National Clearinghouse on Aging is not reauthorized, what activities will the Administration on Aging carry out with respect to the collection and dissemination of information relating to the needs of the elderly?

Answer: The majority of the requests for non-technical information which are handled by the Clearinghouse, are handled directly by staff in the Administration on Aging. The Older Americans Act Amendments of 1981 maintain the Administration on Aging's function to collect and disseminate information on aging and staff will continue to provide this service. Further, these activities are emphasized in our Title IV program. Each grant awarded has a dissemination component, specific awards are made to conduct dissemination activities, and the Aging magazine is used as a vehicle to disseminate information.

EVALUATIONS UNDER OLDER AMERICANS ACT

Question: Your budget justification indicates that evaluation funds under the Older Americans Act may be curtailed in Fiscal 1983. How much is being spent in Fiscal 1982 for evaluation of Administration on Aging programs, compared to your estimate of Fiscal 1983 spending?

Answer: Section 206 of the Older Americans Act of 1965, as amended, authorizes the use of up to one percent of the funds available under the Act for evaluations. Currently, the Administration on Aging sets aside one percent of each of the services accounts (Supportive Services and Senior Centers, Congregate Nutrition Services and Home-delivered Nutrition Services) for such evaluations. In FY 1982, $5,115,000 would be available for evaluations. Our plans call for reserving $1,154,000 for evaluations in FY 1983.

AGING GRANTS MANAGEMENT

Question: How has the Administration on Aging attempted to improve the management of its discretionary grants and contracts during the last year?

Answer: During the past year, the Administration on Aging has been very active in improving the management of its discretionary funds. As part of this effort, an extensive review of existing projects was conducted to determine both project effectiveness and its relationship to the Administration's priorities. Grantees to receive continuation awards were given an opportunity to compete within the framework of review priorities. The projects to be awarded continuation funds, and the amount of funds to be awarded were determined based on this review.

The Administration on Aging has specifically solicited concept papers in five priority areas in the announcement: Employment Opportunities for Older People, Gerontology Career Preparation Program, Knowledge Building and Transfer of Non-services Approaches to Meeting Human Services Needs, Preventive Social Services, and Mental Health Services for Underserved Populations. The Commissioner on Aging will have direct responsibility for the selection, funding and management of these projects.

We are confident that the processes established will optimize the use of these discretionary resources.

Question: What has the Administration on Aging accomplished in the past year to improve research dissemination and utilization?

Answer: The Administration on Aging has taken specific steps to assure that results of Research and Demonstration Projects it supports are being fully utilized, especially by the network of state and area agencies on aging. Funds were awarded to analyze and synthesize the lessons learned from findings and make them available to potential users in a format responsive to their "knowledge and practice" needs. Current and past efforts involve such areas as community care systems, social services, services to the homebound elderly and informal supports. Additional grants and contracts were awarded for provision of technical assistance to communicate research findings to those seeking to improve programs. Administration on Aging staff is participating in dissemination activities, conveying data through conferences, meetings, and information memoranda.

Also, the Policy Study Centers and Long-term Care Gerontology Centers funded by the Administration on Aging have been designed to provide technical assistance and dissemination from a multi-disciplinary approach which aggregates findings from all sources including research, and model projects. In addition, the Administration on Aging believes that efforts to insure utilization begin at the conception of a study and continue through its operation and completion. This is accomplished through the encouragement of input from state and area agencies into the development of research priorities and through "work in progress" presentations at national conferences including the Training Conference of the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

Question: How are research and demonstration results being communicated both to other researchers and to the network of state and area agencies on aging?

The following highlight a few of the most salient activities aimed at disseminating research and demonstration findings, to facilitate their utilization by the field and to enhance their impact beyond the network. The results of research and model projects are being communicated to the network in a number of ways. The award-winning AGING Magazine, published by the Administration on Aging, goes to everyone in the network six times a year and highlights information on research findings and model projects. Older Americans News is a monthly periodical which publicizes significant findings. Conferences such as the National Conference on Abuse of Older Persons include presentations of important research findings. State and local newsletters also incorporate and disseminate such information.

Other major efforts of prime importance include awarding funds to the Gerontological Research Institute to insure that research findings are transmitted to the field in usable form. Handbooks on service development in a variety of areas such as transportation, nutrition, and in-home services are developed and made available to the network. Funds are also used to help potential users apply the results of research to improve services.

Evaluation studies are a specific type of research which is used directly to influence policies and guidance affecting the network. These findings are incorporated in program management and service delivery improvements.

We have also established new requirements and processes to emphasize the importance of communicating research and demonstration results not only to the network but to all potential users of such information. Grant applicants are required to include a dissemination and utilization plan as part of their application. We are now in the process of developing a new system for reviewing the results of research and demonstration projects and identifying findings which are most amenable to immediate use.

The Administration on Aging's multi-faceted approach to dissemination of research findings makes it possible to reach the network through a number of channels using a wide variety of information media and agents. In fact, we reach well beyond our own network through commercial media publication of research findings, even when the Administration on Aging is not recognized as sponsor, such as those related to hypothermia and elderly abuse.

BLOCK GRANTS

Question: This year, the Administration again is proposing the inclusion of serveral programs for children and youth in a social service block grant to states. Why shouldn't the Older Americans Act program be included in a block grant program to states for social services?

Answer. Our FY 83 budget already provides block funding for aging programs. The nutrition program would consolidate AoA state grants with USDA food commodities. The social services program allows states to use those grants for elderly programs.

Question: If the Older Americans Act program is included in a block grant to states, what effects would such a proposal have on older persons receiving services under the current program, and on the administration of the program at the state level?

Answer: We do not know what the effect of a block grant which included Aging would have on older persons receiving services under the current program. Under a block grant, States would have the option of providing services to these persons.

AGING RESEARCH, TRAINING, AND SPECIAL PROJECTS

Question: Why shouldn't the discretionary activities under Title IV--Training Research and Discretionary Project and Programs, which do not, for the most part, directly provide services to older persons--be drastically reduced in order to apply savings in this area to the service programs under Title III, "Grants for State and Community Programs on Aging"?

Answer: The programs under Title IV of the Older Americans Act have been reduced significantly in the last few years. From a level of $40,500,000 available in FY 1981, the program has been reduced to $22,175,000 in FY 1982. The President's request includes $20,307,000 for this activity, a further reduction of 8.4%. The FY 1983 request is necessary to provide adequate support for planned research, demonstration, and training activities. The Title IV program is necessary to support the development of the coordinated, comprehensive service delivery system mandated by the Act. The program also provides leadership in the development of professionals to plan for and administer these services.

MEANS TEST FOR AGING PROGRAMS

Question: In view of the budgetary problems facing the country, why shouldn't the Older Americans Act programs for social and nutrition services be amended to require an income limitation, that is, specifically through the administration of a means test?

Answer: There was no mention in the Older Americans Act, as originally enacted, of a means test or giving preference for low-income or minority elderly. However, it was made clear during the debate on the bill that all concerned intended that the proposed programs not be "welfare" programs; that they be administered outside the welfare context, and that older persons be given to understand that by participating in the programs they were not accepting "charity" or "welfare". While maintaining that income should not be a determining factor in determining eligibility for services, subsequent amendments to the Act added priority to services to low-income and minority elderly, and in 1978 to those elderly persons with the greatest social and economic needs. Clearly, Congressional intent has been not to impose a means test for these programs.

The decision not to propose a means test for programs under Title III of the Older Americans Act was based on the legislative history and the fact that the law allows for provision of services to any older person.

Programs under Title III are providing emphasis on service to the those older persons with the greatest social or economic needs. In FY 1981, states reported participation of persons with the greatest social or economic needs as follows:

	Greatest Economic Needs	Greatest Social Needs
Supportive Services and Senior Centers	51%	42%
Congregate Nutrition Services	60%	46%
Home-delivered Nutrition Services	66%	64%

Current policy provides an emphasis on assuring that these services are available to persons most in need.

GRANTS TO INDIANS FOR THE ELDERLY

Question: Given the small amount of each award to Indian tribal organizations, can social and nutrition services to elderly Indians actually be improved through the Older Americans Act Title VI program?

Answer: The effectiveness of the Title VI program has not been measured. As you are aware, the Title VI program was first funded late in FY 1980 and projects began to operate in FY 1981. We are now in the process of summarizing the results of the first year of operations in terms of services provided, expenditures for the services and staffing patterns.

An evaluation of the program began in FY 1982. The results of this evaluation should provide guidance as to the effectiveness of the program.

Question: Are more Indians actually being served through the Title VI program rather than having funds for Indians funneled through the Title III program?

Answer: In FY 1980, States reported that 39,205 older Indians had participated in the nutrition program under Title III. In FY 1981, states reported that 39,867 older Indians had participated in this program, an increase of 662 older Indians. Thus, during the first year (FY 1981) that programs under Title VI were operating, there was an increase in the number of Indians participating in the Title III program. Since older Indians served with Title VI funds may not receive the same services from Title III funds, one could conclude that Title VI funds have been used to serve more Indians, not to supplement Title III funds.

Question: Wouldn't this latter approach save administrative funds?

Answer: The available data are not such as to permit a conclusion as to whether administrative costs under Title VI are greater or less than would be the case if all funds were funneled through the Title III program. However, if all funds were funneled through Title III, there would be no mechanism to assure that the funds presently awarded under Title VI would go to serve older Indians.

White House Conference on Aging

Question: What have been the results of the White House Conference on Aging and what recommendations have been made for the future of aging policy?

Answer: The 1981 White House Conference on Aging provided over 2000 delegates the opportunity to debate the ways in which the nation should deal with the facts, problems and opportunities of Aging. The Conference effort produced 58 State conference reports, 42 mini-conference reports and 16 technical committee reports, all of which contain recommendations on aging policy in various subject areas. Also, the delegates adopted nearly 700 recommendations at the Conference.

These reports and recommendations are being analyzed in order to prepare the final report of the Conference. The final report, which is required by law to contain a comprehensive coherent national policy on aging, will be transmitted by the Secretary to the President by June 2, 1982.

Question: How much of the total amount of funds available for the Conference have been expended?

Answer: The total amount appropriated for the White House Conference on Aging is $6,000,000 to remain available until expended. Through the end of February, 1982 $5,502,000 has been obligated. The balance of the funds are needed to pay for services for which bills have not been received, to produce and distribute the final report, and to provide for the orderly phase out of Conference activities.

Question: What specific follow-up activities will take place after the Conference?

Answer: Certain specific follow-up activities are required by P.L. 95-478, the 1981 White House Conference on Aging Act. A final report to the President and the Congress is due by June 2, 1982. This report, which will include a statement of a comprehensive national policy on aging, is to be followed within 90 days with the Secretary's recommendations for administrative action and legislation necessary to implement the recommendations contained in the report. In addition to these required activities, a survey form has been sent to each delegate and observer at the Conference, which has allowed them the opportunity to comment on each of the recommendations passed at the Conference. The final report will include an analysis of these recommendations.

CUTS IN NATIVE AMERICAN PROJECTS

Question: The Fiscal 1983 budget request for Native Americans is $23.3 million, a cut of nearly $5 million from the current funding level, and more than $10 million below the Fiscal 1981 level. Specifically what types of activities are being cut in Fiscal 1982, and what further aspects of Native American programs will be curtailed in Fiscal 1983?

Answer: In order to absorb the proposed budget reductions, we are reducing the number of financial assistance grants from 222 in FY 1981 to 179 in FY 1982 and 135 in FY 1983. Corresponding reductions will also occur in training and technical assistance and in the research, demonstration, and evaluation efforts, which support the financial assistance grant program. To some extent, these reductions reflect the phasing out of projects which are not developmental in nature. Funding priority is given instead to those projects which show the greatest promise of enabling the community to develop or implement a balanced approach to social and economic development through locally determined strategies. The purpose of this program emphasis is to eliminate projects which tend to maintain a continuing dependency on delivery of social services in favor of projects which are more likely to result in longer-term development leading to social and economic self-sufficiency.

These reductions are part of the Administration's efforts to reduce the rate of growth of the Federal budget overall in order to help revitalize the economy. We plan to focus assistance to Native Americans on projects which will enable them to benefit from the expected increase in economic activity nationwide. Funding priority is being given to projects which reflect the primary responsibility of local communities to determine, plan, and implement their own long-term strategies for social and economic development. To make up for the loss of Federal dollars, we are encouraging and assisting Native American communities to mobilize and coordinate local resources including volunteers and to increase public and private sector linkages, where possible.

PROGRAMS FOR URBAN INDIANS

Question: 'Apparently the Administration for Native Americans extends its program assistance to urban Indians. Can you tell me what such programs consist of and how much they cost?

Answer: ANA provides developmental assistance to urban Indian projects as well as to a variety of other Native American organizations including tribal governments, off-reservation rural Indian organizations, Native Alaskan organizations, and Native Hawaiian organizations. With respect to urban Indian projects, we estimate that we will spend $3,974,000 in FY 1982 and $3,322,000 in FY 1983.

The overall thrust of all the projects ANA supports is very similar, whether the grantee is an urban Indian center or some other type of organization. The basic purpose is to support the development and implementation of each community's strategy for resolving the underlying social and economic problems which result in unmet human needs.

Question: Are they primarily referral services to assist Indians in applying for aid available to all Americans, or are they programs specifically designed to assist Indians as Indians or Indian Tribes as Indian Tribes?

Answer: The off-reservation projects, both urban and rural, assisted by the Administration for Native Americans, are community-based organizations that carry out a wide range of activities to support Native American self-sufficiency. While the provision of referral and direct social services is an important role of urban Indian centers, a more important role over the long run, and the role which ANA emphasizes, is to assist Native Americans to become self-sufficient through employment, business ownership, and other strategies.

With respect to service provision and referral, urban Indian centers fill both roles. Many Indians live in major urban areas as a result of past Federal relocation efforts or because of a lack of opportunities in their rural home area. In the city, they frequently do not take advantage of social services for which they are eligible and which are intended to be available to all citizens. The service providers may be viewed as inaccessible or they may be unaware of their availability. Urban Indian centers provide outreach to the Native American community to enable those who are in need to gain access to the major social and health service providers in the urban area. This process goes well beyond referral. It also encourages Indian citizens to become more involved in the community decision-making process and to serve on the boards and commissions which operate programs affecting the whole community.

In addition, ANA urban and off-reservation rural grantees administer projects intended primarily for the benefit of Native Americans--projects which meet their special needs. Over eighty percent of the urban Indian centers operate Indian job training programs. Many also run adult education projects, and Indian alcoholism projects located in their centers.

In the past, urban grantees have emphasized core administration, mobilization of resources, and obtaining access to social services for community members. Now, ANA is encouraging urban Indian centers which it supports to help reduce the need for social services by stimulating economic and social progress. For example, in Tulsa, an Indian Chamber of Commerce was established to stimulate greater business activity and growth in Indian owned enterprises. Other communities are supporting similar activities to promote business development and job creation, which we think is the best way to promote eventual social and economic self-sufficiency.

Question: Could you define some of these programs?

Answer: Yes, here are some examples. The Lincoln Indian Center in Lincoln, Nebraska, was established in 1969 to assist Lincoln's Indians, largely made up of members of Plains tribes. The community through the Center has been very successful in gaining access to a wide range of Federal programs and in planning and putting into operation discrete projects that complement or fill gaps in these Federal programs.

One of the strongest suits of the Center is its ability to work with State, local and private providers to increase the access to and quality of programs to Native Americans. Its successful interactions and advocacy with school officials, for instance, permits the Center to operate a complete education department responsive to Indian needs divided into five groups: Day Care; Youth, General Education Development (GED); Junior High and High School; Post Secondary Assistance (career planning); and Adult Education. Without a partnership between the Center and educators, the program could not succeed.

The Native Americans for Community Action (NACA), Flagstaff, Arizona, is an urban center with a special expertise in dealing with Northern Arizona Indian cultures. A component of the Center's Economic Development initiative will foster community growth and well-being through the promotion of private business development. NACA plans to assist and attract potential Indian entrepreneurs who are interested in entering or developing their own small business. Assistance will be given to these entrepreneurs in the designing of sound financial management practices and procedures for their proposed small business. A social and economic resource directory that will identify 80 Federal, State, local, corporate and private resources for Indian individuals, tribes, and organizations will be established. Assistance will also be provided to these Indian entrepreneurs in the completion of such applications as Small Business Administration and Department of Commerce, as well as local financial institutions.

Additionally, the Center operates many other programs such as employment, social services, adult education, youth education and transportation to meet community needs.

As another example, the Boston Indian Council in Boston, Massachusetts was established to assist the approximately 5,000 Indians who reside in and around Boston. The goals of the Council are: to develop Indian leadership within the community, to provide via training and education the opportunities and tools which will enable community members to reach decisions for themselves, and to provide community linkages to those services which the people are rightfully entitled as Indian people and as citizens.

The Boston Indian Council views self-sufficiency in two ways. First, it emphasizes assisting individuals and families to become independent productive members of society and to meet their everyday needs for food, housing, and employment. Second, it wants to support itself as an independent self-sufficient organization by various fund-raising options.

In pursuit of self-sufficiency, the Council has undertaken a comprehensive planning effort. It is developing an integrated service delivery program. It is also investigating potential business ventures such as a community development corporation, and "Buy Indian" programs. They recently obtained a donation of electronic equipment and training in its use from a private corporation, intended to enable Indian people to qualify for jobs in that field. They are exploring the possibility of establishing an Indian-owned business selling office supplies and equipment, as a profit seeking subsidiary. If successful, it would serve as a model for the establishment of other Indian-owned businesses.

The ANA grant to the Boston Indian Council is $95,000, which amounts to only seven percent of their revenues. But it is the only source of funds for long-term planning and management initiatives designed to streamline the organization and make it function more efficiently and effectively. Even day-to-day management functions are difficult to support through the categorical grants that constitute the bulk of their funding. While such grants may provide support for the person directly responsible for managing the particular program, most other funding agencies do not provide support for higher level managers in the organization, such as the Executive Director. Nor do they support efforts that involve looking across programs and into the future.

Question: Do you know if the Administration for Native Americans programs for urban Indians comprise most of the Federal assistance to these Indians, or are there other agencies engaged in substantial assistance programs to urban Indians?

Answer: For most urban grantees, ANA funds make up a small part of their total budgets. Yet, for most grantees, ANA dollars are critical. They enable the organization to look beyond today's problems and short-range needs for service delivery or referral, to the development of long-range plans to assist Native Americans to reduce their dependency on such services. I don't imply here that these community organizations would wither and die without our funds, but the loss of ANA dollars would certainly narrow the approaches communities could take to achieving self-sufficiency.

For example, the Cumberland County Association for Indian People in Fayetteville, North Carolina has an annual budget of nearly a half million dollars including State, Federal and private foundation grants of which ANA's part is $119,000. Using ANA funds the Association embarked several years ago on a planning and resource development effort that has resulted in transportation, nutrition, employment, education, recreational, and cultural programs that are addressing the needs of the Indian community in Fayetteville. Additionally, the advocacy efforts financed largely by ANA have resulted in establishing an Indian presence in over 28 community boards and advisory committees. Their ANA-supported negotiation with the County Commissioners and School Board resulted in a lease agreement that permits occupancy of a large school complex for $1.00 a year.

JOINT FUNDING OF NATIVE AMERICAN PROGRAMS

Question: The Federal Domestic Assistance Catalog description of Native American programs refers to Joint Funding projects. With which programs and agencies have you been involved under the Joint Funding authority?

Answer: As stated in the Catalog of Federal Domestic Assistance, projects funded by ANA are eligible for inclusion in Joint Funding projects, under the authority of the Joint Funding Simplification Act. In past years, we have participated in Joint Funding projects with the Salt River Pima-Maricopa Indian Community in Arizona in cooperation with Head Start, the Department of Housing and Urban Development, and the Law Enforcement Assistance Administration. We participated in a Joint Funding project with the Pueblo of Zuni in New Mexico in cooperation with Head Start, the Bureau of Indian Affairs, and the Economic Development Administration. We also participated in a Joint Funding project to the

Cheyenne and Arapahoe Tribes in Oklahoma with the Bureau of Indian Affairs.

The purpose of Joint Funding is to improve program effectiveness and to reduce the administrative burden on Federal grantees by combining resources from several agencies into a single project. ANA also pursues these goals under interagency agreements authorized by its legislation.

In FY 1981 we administered projects under nineteen interagency agreements with eight other Federal agencies, including the Bureau of Indian Affairs, the Department of Energy, the Department of Commerce, the Department of Labor, the Office of Personnel Management, the Community Services Administration, and the Treasury Department. The projects included support for a Jobs/Skills Bank, an Enterprise Zones project for economic development, a Columbia River fisheries project, Indian census and statistical data project, development of tribal personnel management abilities, and others.

During the current year, we have initiated a Cooperative Management Initiative within the Office of Human Development Services. We are providing consolidated grants to seven Indian tribes to replace separate grants they would have otherwise received from three HDS agencies: ANA, Head Start, and the Administration on Aging. Our purpose is to improve the management of HDS Indian programs in a manner that strengthens tribal governments and promotes the goal of tribal self-sufficiency.

Question: How much was spent in the past Fiscal Year for each of these programs?

Answer: In FY 1981 and in the current year, none of the ANA grantees have requested to participate in a Joint Funding project. However, ANA provided $2,250,000 under interagency agreements and transfers in FY 1981.

Question: What proportion of these joint project funds came from the Administration for Native Americans?

Answer: Under the last Joint Funding project to Salt River, ANA's share was $209,695, or 63 percent of the project total. Under previous projects, it was one-third or less of the total.

Under interagency agreements, ANA usually provides about one-half the total amount of project funding.

Question: In what form and at what time will you submit a request for legislative changes to consolidate Child Welfare Research and Demonstration, Child Abuse, Adoption, Developmental Disabilities Special Projects, and University Affiliated Facilities?

Answer: The consolidated discretionary funds are being requested against a group of existing legislative authorities. No repeals or modifications of existing legislative authorities are being requested.

RUNAWAY YOUTH

Question: What criteria will you use to determine which projects merit Federal support?

Answer: The criteria to be used in distributing State allocations to projects within each State has not yet been determined. The Commissioner, headquarters staff, and State personnel will study projects within each State to determine whether to apply an across-the-board reduction or to make allocations based on the degree of other sources of support available to individual projects.

Question: Does this budget request assume a decline in the number of runaway and homeless youth, or just a reduction in the Federal role?

Answer: We have not assumed that the number of runaway and homeless youth is declining. We do believe that this program is an excellent example of the commitment and involvement of the private sector. On a national basis the dollars provided to centers from the Runaway Youth appropriation represent approximately 35 percent of these centers' total support. As we see local public and private support continuing, we believe Federal support can be reduced without causing adverse effects to the program.

DEVELOPMENTAL DISABILITIES STATE GRANTS

The budget request for the Developmental Disabilities State Grant is $24.7 million, a cut of $16.8 million below the current level.

Question: What would be the impact of a 40 percent cut in this already very small State grant program? Would this leave enough money for a viable State grant program, especially if Congress approves your proposed Bill language to remove the statutory minimum $250,000 State grant?

Answer: The Administration expects the overall impact to be small. We expect that such a reduction in the Federal grant would be substantially offset and replaced by increased assumption of services by the private sector and by expansions of volunteer programs. Such expansion of activity by the private sector and by volunteer programs is being initiated by model demonstration grants being awarded by the Office of Human Development Services this year.

Question: In 1981, the University Affiliated Facilities, now funded under the DD Act, provided services to over 60,000 severely, multiply handicapped children nationwide. These children were referred by State and local programs which because of specialized services needed by these children, were not able to find services anywhere else in the State. Last year Congress earmarked $7.2 million for University Affiliated Facility Projects. Exactly how much do you intend to spend for University Affilitated Facilities in Fiscal Year 1983?

Answer: The amount of funds to be spent on University Affiliated Facilities (UAFs) in FY 1983 will be based on the recommendations of an Ad Hoc Task Force, composed of representatives of the major Federal funding sources for the UAFs, which is to be charged with the development of a long range funding plan for the UAF program, including satellite centers.

Question: Which of the currently funded projects would be curtailed?

Answer: The specific currently funded projects to be curtailed in FY 1983 have not as yet been determined. Funding of UAFs in FY 1982 and 1983 will be based on whether they are in full compliance with the Congressionally mandated standards and on recommendations of the Ad Hoc Task Force which will consider long range funding options.

Question: What will happen to the children who receive services in those States where a reduction or elimination is proposed?

Answer: The Developmental Disabilities program provides funds to UAFs for administrative and operational expenditures so that a reduction in these funds does not mean an automatic reduction or elimination in services to children or any other group under the Developmental Disabilities Program. The major reductions which would affect services to children are occurring in the UAF funding from the Office of Maternal and Child Health, the services that States purchase, third party payments and other Federal grants such as those from the Office of Special Education and Rehabilitative Services, Department of Labor and Department of Housing and Urban Development.

Question: The Developmental Disabilities Act requires (Sec. 122 (c)) expenditures for UAFs authorized under that Act be coordinated with expenditures under the Maternal and Child Health Block Grant. In developing your recommendations for UAFs under the DD Act, what coordination have you undertaken with the Office of Maternal and Child Health which also funds UAFs?

Answer: The requirement in Sec. 122 (c) is that the Secretary establish a process by which other contributing Federal agencies may review the University Affiliated Facilities (UAFs) applications submitted under the Developmental Disabilities Program. Applicants have been advised in the grant application instructions to inform their other Federal funding sources of their proposed activities.

With regard to the Office of Maternal and Child Health, the Assistant Secretary for Human Development Services and the Deputy Commissioner of the Administration on Developmental Disabilities have met on several occasions with the Surgeon General as well as with the Associate Bureau Director of the Office of Maternal and Child Health and other members of his staff to discuss the future of the UAF program. These meetings have led to a close working relationship between the two major funding sources for the UAFs. In addition, staff of these agencies have served on each other's review panels to consider applications for continuation funding and to make recommendations on these submissions.

Question: Last year Congress earmarked $2.5 million for Special Projects for persons with developmental disabilities. Exactly how much do you intend to spend for Special Projects in Fiscal 1983? It should be noted that any reduction would threaten the survival of Developmental Disabilities Councils and the focus on DD persons. As the funds for the Council decrease, fewer projects are produced and less visibility for the DD population is created. A case in point is the traumatic brain injured population. Until the Connecticut DD Council established this population as a priority, no other agency planned for the needs of this population or provided funding for support services to as many as 200 families. This project as well as others are in jeopardy with FY 1983 reductions.

Answer: We have proposed to continue the most productive Special Projects under the Human Resources Research and Demonstration appropriation for FY 1983. The HDS appropriation request of $30,800,000 to support research, demonstrations, training, technical assistance and evaluations in a variety of areas, includes service improvements to the developmentally disabled.

The project on traumatic brain injuries of the Connecticut Developmental Disabilities Council which was described above is not funded under the Special Projects appropriation but rather from the Basic State Grant Program. A cut in the Special Projects appropriation would not necessarily affect the Council activities.

Councils will still survive on thirty-five percent of their current grants. Sixty-five percent of the Basic State Grant must be spent on services so that if the project on traumatic brain injuries is seen as a major State priority it would survive. However, it is anticipated that this program would be funded eventually by other programs (such as Crippled Children's Program, Special Education, Vocational Rehabilitation) since the developmental disabilities funds in the Basic State grant program are intended as seed funds to demonstrate effective services which are to be taken over by other agencies as ongoing programs.

MINIMUM ALLOTMENTS

The figures shown in the proposed budget and the accompanying justifications for State allotments contained in the Office of Human Development Services for the Developmental Disabilities Program eliminate the minimum allotment of $250,000 as authorized by law. This reduces some State allotments to as little as $25,000.

Question: How can a change in the minimum allotment be addressed in appropriations without proposing new language for the authorizing committee to consider?

Answer: We are proposing special appropriation language in this request to cover lower funding level.

Question: Does the Administration propose, whether through appropriations or authorization language, to eliminate the national interest to protect our most vulnerable citizens and to reject the overwhelming intent of Congress to retain the focus and purpose of the Developmental Disabilities Act?

Answer: There is no design on the part of this Administration to subvert the intent of Congress with respect to the focus and purpose of the Developmental Disabilities Act. The overriding purpose of the Developmental Disabilities Act has been to identify major gaps in generic and specialized services for developmentally disabled persons and to coordinate Federal and State programs to fill those gaps. Millions of dollars have also been invested over the years as seed money for the initiation of model services. Model development has now reached a point of diminishing returns. There remains a substantial need for even more active coordination of services and to generate State and local program resources for the perpetual support of services initiated through seed grants. These two activities represent major functions of the Developmental Disabilities program and will continue to be actively pursued at the proposed funding levels.

The Administration has proposed deep cuts in programs for the habilitation, rehabilitation, education, vocational training, and employment of persons with disabilities. The States have traditionally ignored services to the disabled and, in many cases, have provided services only through Federal impetus.

Question: With the States facing their own budget problem and now the threat of cuts from the Federal government, is it the Administration's position that these needs should go unmet if State and local governments decline or are unable to meet them? With the reduced Federal role because of reduced Federal Developmental Disabilities funding, how many developmentally disabled persons will be forced to live in institutions for lack of community support services? What would be the associated cost to taxpayers as a result of the increase of people living in institutions? Does this action not contradict the mandate to assist developmentally diabled persons to achieve their maximum potential in the least restrictive environment?

Answer: The Administration plans to assist State and local governments in supplanting resources reduced by the Federal government through savings in the administrative costs of the programs mentioned. Supplementing this will be a change in the means by which services are provided. Following the lead of the demonstration projects which the Office of Human Development Services is funding this year, the Administration expects there to be a substantial increase in services funded by private organizations and provided by programs utilizing volunteers. Among the foci of these new efforts are improved methods of delivering services, including the increased use of volunteers to provide respite care to families, which will enable handicapped and elderly persons to continue living with their families. The Administration believes that the environment of the family with its personal care and attention is most conducive to the well-being of handicapped persons.

Currently developmentally disabled persons denied services in the community and institutions can seek administrative and legal remedies through the State protection and advocacy office.

Question: Due to the Administration's proposed reduction in funding for other service programs to developmentally disabled persons, the protection and advocacy caseload will increase. If the protection and advocacy funding is also reduced, how many people will go unserved?

Answer: The Administration takes issue with the premise that current and proposed reductions in program funding will necessarily mean a caseload increase for advocacy organizations such as Protection and Advocacy systems. We believe an efficient allocation of available funds by State and local governments to those areas which serve our most vulnerable client groups, combined with increased volunteer and private sector involvement on behalf of these clients, will maintain services at satisfactory levels. There will not be additional impetus to turn to Protection and Advocacy systems for assistance, as a result of what this Administration is proposing.

Furthermore, the Administration proposes maintaining State Protection and Advocacy systems at their FY '81 funding levels to ensure that these vital State agencies continue providing effective and comprehensive assistance to those developmentally disabled persons most in need.

Question: Given the purpose of the Developmental Disabilities Act to coordinate and monitor a State plan to serve the disabled population and to ensure services to the disabled, is it not short-sighted and wasteful of taxpayers' dollars to cut and/or gut programs designed to reduce the dependency of persons with disabilities and reduce future government expenditures for their care?

Answer: This Administration remains committed to the support of developmentally disabled persons in services they require through the resources of the private sector and more active utilization of volunteers. The priority placed on coordination of services and integration of non-Federal resources by the Developmental Disabilities Program will help to ensure that reduction of Federal financial participation will not result in a reduction of services needed by this vulnerable population.

The Developmental Disabilities Act requires as a condition to a State's receiving an allotment the assurance that each program receiving funds have an individual habilitation plan for each developmentally disabled person receiving services. Furthermore, the Act sets requirements and review for such plans. Although educational services, vocational rehabilitation services, and medical services currently require individual planning, the Developmental Disabilities Act is the only plan that incorporates all other plans.

Question: With reduced Federal Developmental Disabilities funding, what is the assurance that individual habilitation planning for developmentally disabled persons will be retained?

Answer: Individualized habilitation plans (IHPs) are a requirement of the Developmental Disabilities Act regardless of the amount of funds allocated to the States through the formula grant. Thus, the reduction in size of formula grant allocations has no effect on the requirement for IHPs so long as these plans are mandated by statute.

Question: How many States currently require IHPs through State statute?

Answer: A recent survey conducted by the Nebraska Governor's Planning Council on Developmental Disabilities revealed that seventeen States now have State Developmental Disabilities authorizing legislation. All of these States either explicitly require IHPs or refer to the Federal Developmental Disabilities statutory requirements.

Question: In 1981, University Affiliated Facilities provided services to over 60,000 severely, multiply handicapped children nationwide. These children were referred by State and local programs which, because of the specilized services needed by these children, were not able to find services anywhere else in the State. What analysis have you done to determine the needs of individuals now served by UAFs?

Answer: The major functions of a University Affiliated Facility are interdisciplinary training, demonstration of exemplary services, and the dissemination of relevant information. Each UAF must analyze the range of services needed by its service population and determine how it can best meet those needs through these major functions. It is not the philosophy of this Administration to determine the needs of individuals and then to mandate the provision of services or training. Rather, the philosophy of the Administration is that States, in this case State Developmental Disabilities Planning Councils, and local governments, are better able to define the service needs of their vulnerable populations.

Question: What plans do you have for seeing that these children do not go unserved?

Answer: It is not the intent of the UAF program, as legislatively defined, to provide services on a continuing basis as may be required by developmentally disabled children. Rather, the charge to the UAFs is to develop exemplary services as models which then can be disseminated and adopted by other service agencies within the community. The primary responsibility for the ongoing provision of services for handicapped children rests with State and local governments, private health and social service agencies, and voluntary organizations. It is this Administration's belief that these groups will not abdicate their responsibility to provide these services.

Question: What are your plans for UAFs if Congress does not concur with these changes?

Answer: Our long-term funding plans, that is beyond FY 1982, will be based on the recommendations of the Ad Hoc Task Force which is to be charged with the development of a long-range funding plan for the University Affiliated Facility (UAF) program, and Federal, Central and Regional Office staff. The recommendations of the Task Force will take into account Congressional deliberations regarding the Human Resources Research and Demonstration authority.

Question: Recent studies of University Affiliated Facilities (UAFs) show that by prevention of developmental disabilities and prevention of institutionalization, that for every Federal dollar spent on UAFs $3.9 to $7.8 dollars of other Federal and State dollars are saved. This savings is accomplished by prevention, improved treatment methods, and by community care instead of institutional care. Are you familiar with these studies?

Answer: Although we are unfamiliar with these particular studies and are unable to attest to the validity of their findings, neither have we reason to contradict their claim that UAFs have been successful in terms of the cost-benefit of services provided to their client populations. Moreover, we believe that if the findings of these studies are accurate, that the State and local communities in which these UAFs are located will be aware of their contributions and will be willing to absorb some of the costs related to their operations.

Question: What analysis have you done of the cost-benefit impact to justify your proposed reduction in University Affiliated Facility (UAF) expenditures?

Answer: In FY 83, University Affiliated Facility funding is provided in the Human Resources Research and Demonstration appropriation. This account consolidates several programs that were authorized and funded categorically in the past, including UAFs. The proposed consolidation will provide greater flexibility in funding and more effective program support for those projects that are funded.

The amount of funds to be spent on the UAF program in FY 1983 and beyond will be based on policy discussions this year resulting in the development of a long-range funding plan for the UAF program.

Question: Do you feel that cuts should be made in University Affiliated Facilities (UAFs) even if other Federal and State costs are significantly increased?

Answer: The shrinking resources available to support social service programs require some re-structuring of the service delivery systems including the service network for developmentally disabled individuals. It is the philosophy of the present administration that State and local governments are best able to define the service needs of their vulnerable populations and to deliver the services efficiently and effectively. The decisions on reductions in funding for the UAF program will be based on the policy discussions this year resulting in the development of a long range plan for the UAF program.

DEFINITION OF DEVELOPMENTAL DISABILITIES

Question: What have been the major positive and negative changes in the program which may be attributable to the revised definition of the term "Developmental Disability?"

Answer: A recent study funded by the Administration on Developmental Disabilities concluded that the current definition of developmental disabilities embraces more types of disabilities and focuses attention more sharply on the more severely disabled.

There has been no substantial increase in the number of individuals who qualify for or who are seeking benefits from the Developmental Disabilities Program. The Developmental Disabilities programs in many States consider themselves no longer responsible for the mildly retarded, those persons with controlled epilepsy, or others whose disabilities are not severe. However, those served who previously qualified but no longer do are continuing to receive benefits and services. There is no substantial body of individuals who have been dropped out of the system.

Many additional conditions are now covered by the Developmental Disabilities program. In some instances, this has resulted in substantive changes in a few programs or services. However, the overall impact on programs and services remains slight, because the total numbers of individuals with these conditions is small.

Question: In view of the criticism set forth in a 1980 General Accounting Office report and the reduced authorization for the Special Projects program, is it reasonable to continue this effort as a discretionary activity?

Answer: Although there were problems noted in the 1980 report of the General Accounting Office which have subsequently been corrected and the funds for the program have been significally reduced, the Special Project program should be continued. In the FY 83 budget submission, we have proposed to continue the most productive special projects. The special projects discretionary program has demonstrated and continues to produce a number of improved methods of service delivery which significantly benefit individuals with developmental disabilities.

In addition, the inclusion of the special projects funds in the FY 82 Discretionary Funds Program has allowed the Developmental Disabilities Program to utilize its limited discretionary resources to leverage or broker the discretionary resources of other agencies. As a consequence, demonstration efforts, which should result in improvements in the developmental disabilities network, are being conducted on much larger scale than would be possible relying solely on the limited developmental disabilities funds.

Question: What progress has been made in developing a clear and consistent focus in the University Affiliated Facilities (UAFs) program?

Answer: The legislation provides a broad authority for the University Affiliated Facilities (UAFs) to develop and conduct activities addressed to interdisciplinary training, the provision of exemplary services to the developmentally disabled and dissemination of findings related to these services. Within this framework, each UAF has developed according to the orientation and expertise of their institution, faculty and staff, the resources they have been able to command, the needs of the clients they serve and the communities in which they are located. While this uniqueness and diversity has been regarded as a strength of the program, a common focus and direction are also present as manifest, for example, in the adherence of the UAFs to standards as Congressionally mandated in the Amendments of 1978. Full compliance with these standards will be obligatory by August of this year.

In addition, there have been numerous meetings over the last year involving the Assistant Secretary for Human Development Services, the Acting Commissioner on Developmental Disabilities and their respective staff members to discuss and plan for the future of the UAF program. There have also been frequent meetings with the Director of the Office of Maternal and Child Health and his staff to discuss and resolve common issues and problems. Furthermore, dialogue has been maintained between the UAFs and the Administration on Developmental Disabilities to convey information on the priorities and goals of this Administration as they affect the UAF program.

In terms of long range support for the UAF program, we will be appointing a Blue Ribbon Task Force charged with the development of a long range programmatic and funding plan for the UAFs and Satellite Centers.

Question: Your opening statement indicates you will continue the most productive university affiliated facility projects, for which $7.2 million is currently available in Fiscal 1982, serving individuals such as the mentally retarded. Exactly how much do you intend to spend for university affiliated facilities in fiscal year 1983?

Answer: To develop plans for long range (beyond FY 1982) funding of the University Affiliated Facilities (UAF) program, an Ad Hoc Task Force will be appointed. This panel will include representatives from the major Federal funding agencies, such as the Office of Maternal and Child Health and the Administration on Developmental Disabilities in the Department of Health and Human Services and the Office of Special Education and Rehabilitative Services (OSERS) in the Department of Education, as well as representatives of UAF programs.

Question: Which of the currently funded projects would continue, and which would be curtailed?

Answer: Continuation awards in FY 1982 will be made on a competitive basis. Those projects which are selected during the FY 82 competition would be eligible for consideration for FY 83 funding, based on the recommendations of the Ad Hoc Task Force.

Question: As mentioned in our opening statement, we propose to continue the most productive university affiliated facilities under the Human Resources Research and Demonstration appropriation. The placement of these funds in this appropriation category would allow greater flexibility in the use of these funds and provide the leverage to utilize a wider range of discretionary resources than possible with a specifically marked line item. It will also increase our ability to target a broader spectrum of the developmentally disabled population. This will enable States and localities to concentrate on individuals of all ages, regardless of the multiplicity or severity of their handicaps.

Question: The Developmental Disabilities Act requires expenditures for University Affiliated Facilities (UAFs) authorized under that Act be coordinated with expenditures under the Maternal and Child Health Block Grant. In developing your recommendations for UAFs under the Developmental Disabilities Act, what coordination have you undertaken with the Office of Maternal and Child Health which also funds UAFS?

Answer: The requirement in Sec. 122 (c) is that the Secretary establish a process by which other contributing Federal agencies may review the UAF applications submitted under the Developmental Disabilities Program. Applicants have been advised in the grant application instructions to inform their other Federal funding sources of their proposed activities.

With regard to the Office of Maternal and Child Health, the Assistant Secretary for Human Development Services and the Deputy Commissioner of the Administration on Developmental Disabilities have met on several occasions with the Surgeon General as well as with the Associate Bureau Director of the Office of Maternal and Child Health and other members of his staff to discuss the future of the UAF program. These meetings have led to a close working relationship between the UAF's two major funding sources.

Question: It is reported that the Administration on Developmental Disabilities is currently considering a proposal which would eliminate funding, in effect, for an estimated 16 University Affiliated Programs (UAFs), while doubling funding for certain remaining UAF programs. In addition, it is reported that you are considering the total elimination of UAF funding within three years. Why are you doubling funding for programs in this fiscal year when you only plan to eliminate them later on?

Answer: Awards for FY 1982 will be made at higher funding levels, to fewer UAFs, on the basis of competition. This will assure the adequate level of funding necessary to maintain high quality programs, to attract alternative funding sources, and to compensate for inflationary increases. The number of successful competitors will be based on compliance with grant criteria, specifically including achievement of 1978 mandated standards for UAFs.

The long range funding plan for the UAF program will be based on internal policy discussions and recommendations from the Ad Hoc Task Force to best determine the funding directions in this era of shrinking resources. The current plan is to include the UAF program in the Human Resources Research and Demonstration appropriation in FY 1983. The most productive UAFs will be continued under this appropriation.

Question: University Affiliated Facilities (UAFs) serve about 67,000 children nationwide who have severe cases of mental retardation and are in need of intensive treatment and elaborate diagnostic care. What will happen to the children who receive services in those States where UAFs are targeted for elimination?

Answer: It is not the intent of the UAF program, as legislatively defined, to provide services on a continuing basis as may be required by developmentally disabled children. Rather, the charge to the UAFs is to develop exemplary services as models which then can be disseminated and adopted by other service agencies within the community. The primary responsibility for the ongoing provision of services for handicapped children rests with State and local governments, private health and social service agencies, and voluntary organizations. It is this Administration's belief that these groups will not abdicate their responsibility to provide these services.

Question: Why should Congress abolish University Affiliated Facilities as a specific line-item in the Budget?

Answer: The consolidated discretionary funds would allow for flexibility and efficiency in planning a coordinated discretionary program across Human Development Program.

STATUS OF CHILD WELFARE BLOCK GRANT LEGISLATION

Question: What is the status of your Legislative Proposal to consolidate Child Welfare Services, Child Welfare Training, Foster Care, and Adoption Assistance into a single, flexible Block Grant?

Answer: The draft bill has been sent to OMB and is under review there.

Question: How exactly would this new Legislation reduce the burden of Federal Regulations?

Answer: States would no longer be required to submit jointly developed child welfare services plans, estimates of expenditures, or quarterly statements of expenditures.

Question: If this legislation is not enacted in time for consideration during action on Fiscal 1983 Appropriations, what level of funding will the administration support for the existing program?

Answer: We would request $380 million.

ADOPTION OPPORTUNITIES

Question: How is the Adoption Opportunities Program absorbing the cut in funding from $5 million in fiscal 1981 to $2 million in fiscal 1982? Are any particular components of the program being eliminated to absorb this funding cut?

Answer: We are absorbing the cuts in the following ways: by consolidating the Regional Adoption Resource Centers with the other two ACYF Regional Centers in child abuse and neglect and child welfare training, so there is one comprehensive Center for Children and Youth Services in each region; by adhering to our original schedule to end a number of projects in September, 1982, such as the adoption training curriculum and the national adoptive parent project; and by funding new starts, such as the consolidated Regional Resource Centers for Children and Youth and the National Adoption Exchange System at a reduced level.

We are seeking to reduce funds without eliminating any ongoing projects completely, although the consolidation of the regional resource centers does mean the Adoption Resource Centers will be phased out as separate entities.

Question: What coordination is there between the adoption opportunities program and the data-gathering components of the adoption assistance program?

Answer: P.L. 95-266 provides for the establishment and operation of a national adoption and foster care data gathering and analysis system utilizing data collected by States pursuant to requirements of law. This section is linked to P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, Sec. 476 (a) and (b), which requires the Secretary to periodically collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country. "Each State shall submit statistical reports as the Secretary may require."

The Department has in cooperation with the 50 States, the American Public Welfare Association, and the National Governors Association developed a reporting system which will collect aggregated State-specific data on children in foster care and adoptions. The States are now reviewing the final draft of the proposed reporting manual in preparation for submission to OMB.

The Secretary will in the near future determine whether such annual State reporting will be mandatory or voluntary. It is expected that such reporting will be implemented by the second half of FY'83.

Question: Now that the Model State Adoption Act has been completed, could the rest of the activities now being carried out by the Adoption Opportunities Program be carried out by the Adoption Assistance Program instead?

Answer: No, these programs are under different authorization and are designed to carry out different kinds of efforts. The Adoption Opportunities Program is a discretionary program, designed to carry out certain specified nationally focused activities to help eliminate barriers to the adoption of special needs children. Public Law 96-272, which includes adoption assistance, is a state formula grant program intended to provide states with funds to operate state child welfare programs.

IMPACT OF CHILD WELFARE BLOCK GRANT ON DISCRETIONARY SERVICES

Question: You are requesting $380 million for the proposed new Child Welfare Block Grant. In fiscal 1982, $465 million has been appropriated for comparable programs, of which $305 million is for foster care and adoption asssistance entitlement payments. As you know, the Congress has rejected previous proposals to cap these entitlements. Assuming that Congress is again unwilling to place a cap on these entitlement payments in fiscal year 1983, isn't there a danger that most of the $380 million budget request would be absorbed for mandatory foster care payments, with very little left over for Child Welfare and Training services?

Answer: If the block grant is not enacted and no cap is placed on foster care, most of the $380 million might be absorbed by foster care. This increase in cost is one of the reasons that we are proposing the block grant.

Question: Wouldn't this defeat the purpose of the law, which is intended to de-emphasize reliance on foster care, and get children into permanent, adoptive homes?

Answer: The entitlements include adoption assistance which supports getting children into permanent homes. However, adoptive services would probably be limited.

Question: What is your current estimate of foster care and adoption assistance entitlement payments in each of fiscal years 1982 and 1983?

Answer: We estimate a combined total of $357 million in fiscal year 1982 and $397 million in fiscal year 1983 for foster care and adoption assistance. The FY 1983 estimate assumes a continuation of current statutory authority.

FOSTER CARE SERVICES UNDER THE CHILD WELFARE ACT

Question: The 1980 Adoption Assistance and Child Welfare Act was intended to stem the increase in State foster care caseloads, both to reduce costs and to preserve families. Has the nationwide foster care caseload been decreasing?

Answer: The federal government does not currently have a data collection system in place which would provide this information. Reports from the Office of Family Assistance, which had been administering the title IV-A Foster Care Program until June, 1981, show that in this segment of the States' total foster care system, 102,726 children were receiving assistance in March of 1981, as compared to 101,000 children in March, 1980.

Question: Has the number of foster children being placed for adoption been increasing?

Answer: Communication with Regional and State child welfare staff and other observations have lead to conclusions that more children are being adopted from child welfare caseloads than earlier periods. We believe that this is because of national emphasis over the past five years on permanency planning and particularly on overcoming existing biases in many States against adoption by foster parents on their foster children.

Question; Have the States shown an improvement in reuniting families from which a child has been removed?

Answer: We do not yet have nationwide data which would provide this information. However, with limited facts available at this time, we know that some States which have made major investments in planned reunification and preventive services programs show dramatic results.

Question: Have there been any innovations in State-provided services to rehabilitate and reunite families?

Answer: The most impressive innovations in recent years have been the permanency planning projects, which have become state-wide practice in some States. A fairly recent, and as yet limited, movement has been in home-based services for children and families, which embodies a commitment to making the first and greatest resource investment in caring for children and their families in their own homes before more radical substitute care approaches are used.

CHILD WELFARE TRAINING

Question: What are the fiscal 1983 training priorities for the Child Welfare Training Program?

Answer: Training priorities would be established by the States under the proposed Child Welfare Block Grant.

Question: How are training priorities set?

Answer: It would be the decision of each State as to how to set training priorities under the proposed Child Welfare Block Grant.

Question: Is there any consultation with State or local agencies to determine what their training needs are?

Answer: Yes. Currently the Children's Bureau staff and the Child Welfare Training Centers consult on a regular basis with State and local agencies to determine what their specific training needs and priorities are.

Question: What are the pros and cons of consolidating the child welfare training program into a State block grant for social services?

Answer: The pros are that such a consolidation will give States more control over their own resources, and will allow them more flexibility and choice about responding to their own, most critical needs.

The cons are that training may not be a high priority for some States, and the number of trained professionals would diminish.

Question: Is the need for professionally trained child welfare workers going to expand indefinitely?

Answer: We do not have specific information projecting the need for trained workers in the future.

Question: What are the latest statistics on the number of child welfare workers, compared to the number of children who need them?

Answer: The 1977 a national study conducted for the Children's Bureau estimated the number of children receiving public social services at 1.8 million. Figures for the number of workers were not included in this study; however, it is estimated that the national public child welfare system includes approximately 30,000 workers and 5,000 supervisors.

Question: How many positions are expected to be available in the future for child welfare workers with advanced degrees?

Answer: We really do not know how many positions will be available for workers with advanced degrees.

FOSTER CARE

Question: How many States had implemented the foster care protections required in P.L. 96-272 and were therefore eligible for their full IV-B allocation in FY 1981? How many recieved it?

Answer: During FY 1981, thirty-four (34) States indicated through signed certifications that they met the foster care protections as specified in section 427 of the Social Security Act as amended by P.L. 96-272.

Because of these self-certifications all thirty-four of these States were deemed eligible to receive their full title IV-B allocation for FY 1981 and all thirty-four of them received it.

Question: Was there any Federal monitoring of States that received their full IV-B allocation in FY 1981 to ensure that they were, in fact, in compliance with the law regarding foster care protections?

Answer: Program reviews designed to evaluate overall child welfare service delivery systems in the States were conducted in 18 States in FY 1981. Ten of these were in States which had certified their eligibility under section 427.

Question: Has there been any Federal Assistance to the States to help them comply with the requirements concerning foster care protections?

Answer: Section 422 of the Social Security Act requires every State to submit a "plan for child welfare services which has been jointly developed by the Secretary and the State..." prior to receiving its title IV-B funds. The majority of these plans specifically address one or all of the section 427 requirements, sometimes, in great detail. These plans were generally developed with the close involvement of the Regional Children's Bureau staff whom the States requested to participate in the joint planning process.

Also, several ACYF Regional Offices sponsored State meetings and conferences where training and orientation to the section 427 requirements were given by both Regional and Central Office Staff.

COST TO FUND EXISTING LAWS

Question: Since this is an Appropriations Committee, not an Authorizing Committee, please tell us how much would have to be added to your budget requests if no changes were made in existing statutes for Fiscal Year 1983?

Answer: For the four programs that we are proposing be replaced by the Child Welfare Block Grant in Fiscal Year 1983, we are asking $380 million. If the block grant is not enacted, we would continue to request $380 million.

REDUCING INSTITUTIONAL FOSTER CARE COSTS

Question: How can institutional foster care costs be reduced?

Answer: Institutional costs can be reduced by: using institutions only when necessary, determined by an informed assessment of the child and family's needs, and assessment of alternative resources; requiring institution programs to deal specifically with the assessed needs of the child and family.

Question: How many children really need institutional foster care in preference to foster family care?

Answer: The percentage of children in foster care who are in institutions varies from approximately 12 percent to 50 percent among the States. Assuming adequate support and alternative services are available we would expect rates at the lower end of the range to be practicable.

Question: What approaches could be taken to reduce State reliance on institutional foster care?

Answer: An increased availability of services to troubled families to help them remain together, and specialized family foster home programs would reduce the need. These include: services to the child's home, including homemaker services, counseling, day care as a preventive service, and day treatment.

A heavy emphasis upon permanency planning by institutions would reduce the quantity needed. This includes the heavy involvement of families of children in institutions, an emphasis upon helping the family as much as treating children, provision of after-care services, making shorter stays possible, and an aggressive activity toward adoption when the parents are not a resource.

Question: What factors in the foster care program -- the statute, the federal regulations, state practices, or agency practices have of encouraging institutional foster care?

Answer: Prior to enactment of P.L. 96-272 the lack of emphasis upon prevention, restoration and adoption encouraged overuse and long stays in institutions. The efficacy of that law has not been tested but offers solid promise by supporting incentives for Child Welfare Services rather than foster care.

Question: How can abuses of institutional foster care, such as private agencies overcharging States, and States inflating claims, be detected?

Answer: Abuses can best be corrected by careful review of submitted claims. State agency capability to conduct fiscal audits of agencies from which services are purchased should be encouraged.

In addition, the HHS Audit Agency staff are placing more emphasis on on-site reviews of foster care, including overcharges for institutional costs, to the extent that staff and travel funds permit.

CUT IN CHILD ABUSE FUNDING

Question: Your budget justification cites a 17 percent increase in reported child abuse cases in the last two years, yet the budget proposes to cut current funding of $6.7 million down to $4.6 million in fiscal year 1983. Is it your intent to phase out all currently-funded prevention and treatment projects, in order to limit the federal role strictly to technical assistance and dissemination of information?

Answer: No, that is not our intention. The budget request for $4.6 million is the amount to be allocated for the Child Abuse and Neglect State Grants Program. Its propose is to assist states in developing and improving their child protective systems, as specificed in Section 4(a) of the Child Abuse Prevention and Treatment Act. Eligible States may continue to support their own pilot projects or to make system improvements using this grant support, in keeping with their own priorities and needs.

Question: Over the years, is there any evidence that Federal project grants have been effective in reducing child abuse?

Answer: Most of the progress to date has been achieved in the area of identifying children who have been abused or neglected and preventing their continued maltreatment. There has been a study, focused on child protective cases in Denver, which indicated that while reports of abuse and neglect have risen significantly -- representing greater sensitivity in uncovering maltreated children -- the severity of cases has declined. This finding suggests that the gread increase in reporting of child abuse and neglect has had the valuable effect of allowing child protective action to occur before children were severely, perhaps even fatally, abused or neglected. In terms of prevention of recurrence of abuse and neglect, which have been shown to be chronic patterns of parental behavior, the increase in reports and follow-up child protective actions are evidence of a reduction of child abuse.

Question: What can the Federal government hope to do to reduce the incidence rate of one million children who are seriously abused or neglected each year?

Answer: The Federal government does help to reduce the incidence of child maltreatment by serving as an information broker for States, local communities, private professionals and citizens who are engaged in devising effective prevention programs, increasing professional and public awareness of endangered children, supporting better reporting systems, and improving child protective service intervention and family support and remedial services. The Federal government has played a significant role in focusing public attention on this problem, in exploring new avenues to effect prevention and treatment and in collecting and disseminating useful, practical program information. Our budget proposal for fiscal year 1983 proposes to continue that role. We still believe that this role is an important one which is of significant assistance to those who carry principal responsibility to prevent child abuse and neglect.

CHILD ABUSE/SELF HELP

Question: Parental self-help groups such as Parents Anonymous and Parents United have been shown to be extremely effective in preventing and treating child abuse and sexual abuse, and in rehabilitating families that experience these problems. What approaches can the Federal government take in encouraging these groups to continue and expand?

Answer: In its brokerage role, the Federal government has encouraged and will continue to encourage State public social service agencies to make formal and informal linkages with both of these very effective parental self-help organizations. In fiscal year 1982, financial assistance is being provided to Parents Anonymous to inaugurate a new adjunct program of services for the abuse children and adolescents of Parents Anonymous members, as a remedidal and preventive program. Parents United organizations are being supported by a number of Federally funded child sexual abuse service improvement projects scattered in various parts of the country.

Question: Is there a legitimate Federal role in funding and supporting these private, self-help groups such as Parents Anonymous and Parents United?

Answer: We believe that there is a legitimate but limited Federal role in supporting such organizations. We believe that the strength of the individual state and local chapters results from their emphasis on self-help, voluntariness, and reliance on local resources. Our intent is to stimulate the grouth of such efforts without fostering dependence on Federal funds.

CHILD ABUSE

Question: In FY 1981, eight States were still not eligible for the State grant program under the Child Abuse Prevention and Treatment Act. Are these States not elibible?

Answer: The eight States still not eligible as of FY 1981 were Alaska, Oregon, Idaho, Arizona, Indiana, Wisconsin, Pennsylvania and Maryland. In the majority of the ineligible States, legislative bodies have been unwilling to entertain the necessary legislative changes to meet the requirements specified in the Child Abuse Prevention and Treatment Act.

Question: Have the eight States that are ineligible for the State grant program made an effort to become eligible?

Answer: At this point, we are aware of efforts being made by Idaho and Maryland during FY 1982.

Question: Has the National Center on Child Abuse and Neglect provided any assistance to enable States that are ineligible for the State grant program to become eligible?

Answer: Yes, the National Center, through Central Office and Regional Office Staff, through consultant legal experts and through its Regional Child Abuse and Neglect Resource Centers has provided continuing assistance to the ineligible States. In the majority of the inelibible States, legislative bodies have been unwilling to entertain the necessary legislative changes to meet eligibility requirements specified in the Child Abuse Prevention and Treatment Act.

Question: What would the effect be on the Child Abuse program if it were consolidated into a block grant to States?

Answer: As you know, we asked in our original fiscal year 1982 budget that the Child Abuse program be consolidated into the Social Services Block Grant. This request was not made in FY 1983. While the effect would be to reduce a Federal focus on the problem of child abuse and neglect, the block grant approach would allow States more flexibility in providing services, including child protective services.

Question: Would States continue their child abuse prevention activities if the Child Abuse program were put into a block grant?

Answer: Yes, we believe they would. Since the great majority of child protective services are not funded by the Federal Child Abuse program, but by State appropriations and Federal assistance through the Social Services Block grant program and the Child Welfare Services Program, it seems clear that the majority of child abuse related programs would continue.

Question: Could private groups such as Parents Anonymous and Parents United -- which have been shown to be very effective in preventing chils abuse and rehabilitating abusive families -- continue if the Child Abuse program were put into a block grant?

Answer: These two national programs would still have competitive access to the Social Services Discretionary Activities program of the Office of Human Development Services as national programs having multi-state impacts. In addition, State and local units would have access to block grant funds under States as well as to other public and private resources.

FEDERAL CHILD ABUSE ROLE

Question: Since most child abuse cases are investigated by State child welfare workers and handled by State or family courts, what is the Federal role in preventing and treating child abuse?

Answer: The Federal role has been, since the enactment of the Child Abuse and Treatment Act of 1974, one of assisting States and local communities, public and private agencies to improve their capabilities to prevent and treat child abuse and neglect. The National Center on Child Abuse and Neglect has provided a forum and some financial support for exploration into the nature and the causes of various forms of child maltreatment which still pose especially vexing problems for child protective workers -- such as sexual abuse, maltreatment of adolescents, maltreatment related to alcohol and drug abuse, and life-threatening forms of neglect. With this process now well underway, a continuing Federal role is to serve as an information resource - collecting, analyzing and disseminating new and practical knowledge to equip those responsible for handling identified cases and preventing and treating child abuse and neglect.

IMPACT OF FEDERAL CHILD ABUSE FUNDING

Question: In light of the increasing numbers of reported child abuse cases, what good had our Federal investment done in addressing this problem?

Answer: The Federal investment in the National Center on Child Abuse and Neglect and its programs has been instrumental in focusing attention on children whose physical and emotional well being was endangered by abuse or neglect at the hands of those responsible for their care. Federal efforts have had the effect of increasing reported instances of abuse and neglect by assisting States in calling attention to the plight of children in need of protective attention, but not increasing incidence. In the short term, increase in reports had to be considered a sign of success, in reaching those children who before had remained hidden and unprotected. More recently, however, the increase of reporting has begun to level off, with a rise of less than 10% between calendar years 1979 an 1980, as compared with a rise of approximately 17 percent in the previous year. Yet, the National Study of the Incidence an Severity of Child Abuse and Neglect, carried out between May 1979 and April 1980, found that two out of every three observably harmed abused or neglected children were still not reported to child protective authorities. The National Center on Child Abuse and Neglect, has had the effect of sharpening State laws and disseminating extentive practical program information and enhancing the awareness of professionals and citizens at large.

CHILD ABUSE SERVICES

Question: What new services to prevent child abuse and neglect have been developed with the help of Federal dollars?

Answer: Among the new services stimulated by Federal research and demonstration funds are: perinatal screening of families at rist of parent-child problems; use of procedures to enhance parent-child bonding and intensive parent support to young parents in hospital obstetrics wards; support for parent aid programs using paraprofessionals and volunteers to provide intensive support services to families at risk of abuse and neglect and to prevent the need for out-of-home placement during treatment; various parent education approaches, including the use of puppet theatre for yound children and street theatre and television to reach adults; new review and reporting systems for handling abuse and neglect in residential institutions; remedial groups for young children and adult; use of therapeutic family day care homes for at-risk children with concurrent parent education on better child-rearing approaches; and use of group therapy for adolesent victims of intrafamily sexual abuse.

Question: Do these preventive models have universal application?

Answer: They appear to have universal application in the sense that they can be used in any community of any size in the country with diverse populations.

Question: In allocating Federal money to the child abuse problem, how is the balance between prevention and services determined?

Answer: Allocation of Federal funds awarded as State grants is the prerogative of the eligible States that receive them; however, in FY 1982 the National Center has provided a number of preventive models to State child protective service officials with the request that they be considered as replicable pilot projects for the use of the current year's State grants. Since 1978, a sizeable portion of discretionary funds has been allocated specifically to prevention efforts. We estimate that 40% of discretionary funds currently support prevention strategies.

RUNAWAY YOUTH PROGRAM

Question: What effect has the new allocation formula had on the Runaway Youth Program?

Answer: A comparison of actual expenditures by States prior to the new allocation formula with each State's allocation in FY 81 indicated that the 57 total State jurisdictions, 29 States benefited from the new allocation formula, while 28 received less funding than they had received prior to the new formula.

Question: What are some of the positive aspects of this change?

Answer: The incidence of youth running away from home is a national problem, shared at least in some degree by every State. The new formula allocation, which is based on each State's youth population, assures that every State will receive Federal support to provide services to runaway and homeless youth.

Question: What are some of the negative aspects of this change?

Answer: The primary negative aspect is that money could no longer be allocated for programs based on the additional factor of actual runaway youth. Many State jurisdictions, because of their geographical locations, tend to have large numbers of young people runing either through them or to them (i.e., Florida, District of Columbia, Maryland, New York, Minnesota, Texas, Arizona, New Mexico, California, Colorado, Illinois and Indiana); which necessitates additional service agencies to serve the increased number of young people which do not reside there permanently.

Question: What is the role of the Federal government in addressing the runaway youth program?

Answer: Research data has clearly established that running away is in fact a national problem; not restricted to a particular geographic region, social class or ethnic group. In recognizing the "interstate nature" of this problem, the statute established (Title III, Sec. 302(5)) that "... it is the responsbility of the Federal government to develop accurate reporting of the problem natonally and to develop an effective system of temporary care...".

Question: What is the role of the States?

Answer: The States should be encouraged to address the needs of youth and families in crisis by strengthening and establishing support to locally controlled centers in order to prevent and address family dysfunction, truancy, criminal involvement, substance abuse, sexual exploitation and physical abuse of young people.

Question: What is the role of the cities?

Answer: In addition to a similar role as outlined for both the Federal and State responsibilities, cities should be strongly encouraged to use existing services and develop additional linkages with other social services agencies to increase program capabilities in dealing with young people and their families in times of crisis.

IMPACT OF BLOCK GRANT ON RUNAWAY YOUTH PROGRAM

Question: If the Runaway Youth Program were either cut substantially or consolidated with other programs, what would the effect be?

Answer: ACYF is now, and would continue to work with the grantees to assist them to find alternative funding sources to minimize the impact of any reduction in funding levels. We have no specific information on what the effect of consolidating would likely be.

Question: Would many States choose to use State funds to support or to supplement Federal support of Runaway Youth Shelters?

Answer: Over one-third of 165 centers currently funded recieve funds from State resources. In addition, local public and private resources support these centers. State sources, together with other Federal support, such as Title XX, and local public and private resources represent 65 percent of the total support for these centers. The Runaway Youth program provides the remaining 35 percent. We expect the State and local public and private support for these centers will continue.

HEAD START PROGRAMS IN THE TERRITORIES

Question: How many Head Start programs are there in the Territories?

Answer: There is one project in the Virgin Islands and eight projects in the outer Pacific Islands.

Question: How much funding did the Territories receive in Fiscal 1981? In Fiscal 1982?

Answer: The on-going funding level for these projects was $3,834,792 in FY 1981. In Fiscal 1982, $4,084,053 is being alloted to these projects.

Question: How much funding for the Territories is projected for Fiscal 1983?

Answer: For FY 1983 we plan to maintain the FY 1982 funding level of $4,084,053.

Question: Have the Territories been able to maintain enrollment levels in light of the lower proportion of Head Start funding that is reserved for this purpose?

Answer: The requirement in the 1981 reauthorizing legislation that not more than 1/2% of the Head Start appropriation be used for projects in the territories has had no effect on the funds provided to these projects or on their enrollment. Current funding is considerably under statutory ceiling.

SWITCH IN RATIONALE BEHIND HEAD START BUDGET

Question: Your budget request claims there will be no reduction in the current level of 377,300 children served by Head Start projects - despite the fact that local grantees will receive only a $5 million increase in fiscal 1983, less than 1 percent.

How do you explain the reversal in the Administration's position that somehow management efficiencies will now permit local grantees to offset inflation, provide salary increases, and maintain quality services -- whereas last year's budget argued for significantly increased funding to avoid deterioration of program quality?

Answer: While marginal management efficiencies in local Head Start projects have been achieved in past years, an organized comprehensive effort could not be launched since the cost analysis techniques needed to accomplish savings of the magnitude alluded to in the FY 1983 budget request were not ready for use in Head Start. During the latter part of FY 1981 and the beginning of FY 1982 the Department conducted an exploratory short-term evaluation of Head Start cost performance data. This exploratory activity, coupled with a newly developed cost analysis management initiative will enable us to work with grantees to achieve mor extensive cost savings than were possible in earlier years.

Question: How much are you estimating will be saved through administrative efficiencies n fiscal 1983?

Answer: We have not made an estimate of savings which can be achieved specifically through administrative efficiencies by local programs. We believe that there are steps which local projects can take to operate more efficient or economical programs. We are confident that program quality and enrollment will be maintained in FY 1983.

Question: Will savings be achieved as the result of proposed new Head Start Federal regulations?

Answer: We anticipate that there will be minor, but not significant, cost savings resulting from new Head Start regulations. The regulations are being revised to simplify existing standards and provide greater flexibility to local programs in areas where it is appropriate to do so. The revised regulations will not diminish the scope or quality of Head Start and will not require cut backs in program services which would produce major cost savings. We anticipate that reduction of unnecessarily restrictive standards will allow local administrators to achieve some savings through more efficient management.

Question: If it turns out your projections of administrative efficiencies prove unrealistic, will you request extra funds to keep Head Start enrollees at the current level?

Answer: We do not plan to request additional funds for Head Start during FY 1983. Aside from the overriding need to control Federal spending in order to aid national economic recovery, we expect that the economies and added non-federal resources available to local projects will be sufficient to enable enrollment and program quality to be maintained.

Question: Will lcoal project sponsors be given the option of reducing the quality of services?

Answer: No, our policy nationally will be to work with local projects to enable them to maintain both current levels of program quality and current enrollement during FY 1983. Levels of quality consistent with the requirements of Head Start's comprehensive Performanct Standards will be maintained.

LOSS OF HEAD START SUPPORT SERVICES

Question: How can the Head Start program be maintained, as the Administration has claimed, when other supportive programs such as Medicaid, the child nutrition programs, and CETA will no longer be able to provide the same level of support to Head Start grantees?

Answer: While CETA workers provided useful services to the Head Start program, some did not provide essential services. In the case of classroom teaching staff, the FY 1982 budget provided increased funds, part of which are being used to ensure that serious problems of inadequate adult to child ratios are corrected, including replacing lost CETA classroom staff in some programs.

With respect to Medicaid, Head Start will compensate for these reductions by linking children with all available community health resources such as health departments, children and youth centers and voluntary services organizations. However, the losses to Head Start may not be extensive. For example, in 1981 34 states were extending Medicaid/EPSDT services to the medically needy, in addition to children categorically eligible for EPSDT. The department has information to date that only one of these states has restricted the population of children eligible for EPSDT. Only 320 Head Start children are affected by this state's action.

It is difficult to determine the extent of funding which may be lost to Head Start as a result of reductions in the child nutrition programs, since it is up to the states to decide how and where they wish to spend the $488 million in the proposed FY 1983 General Child Nutrition Assistance Grant.

To the extent that Head Start funding is necessary to maintain the quality of the program in these areas, local programs are expected to plan for these circumstances, seek additional local resources, and achieve cost effeciencies through the use of cost analysis techniques to absorb the additional expenditures.

HEAD START/CETA

Question: In Fiscal Year 1981, how many Comprehensive Employment and Training Act (CETA) workers were employed in Head Start programs?

Answer: Head Start projects began to lose CETA workers during FY 1981, as the CETA public service employment program was phased out. FY 1980 was the last year in which CETA workers fully participated in Head Start. In that year, projects reported that they had approximately 4,000 CETA job slots.

Question: How many programs used one or more CETA workers?

Answer: In FY 1980, the last year in which CETA workers fully participated in Head Start, 877 projects, or about 70% of all projects, reported using CETA workers.

Question: What was the total cost of wages paid these CETA workers?

Answer: We estimate that in FY 1980, the last full year in which the CETA public service employment program operated, the cost of wages paid to CETA workers employed in Head Start projects was $22 million.

Question: What kinds of jobs did they do?

Answer: CETA employees have performed various jobs such as teachers aide, social services/parent involvement aide, nurse's aide, clerk-typist, bus driver or aide, and administrative aid. In a relatively few instances, they occupied the position of a teacher, social services/parent involvement specialist, bookkeeper or component coordinator.

Question: In Fiscal Year 1982 and beyond, how will Head Start programs compensate for the loss of all public service employment positions under CETA?

Who will do these jobs, and how will they be paid?

Answer: Although CETA workers provided useful services, some did not provide essential services and Head Start projects did not necessarily have to replace all lost CETA workers. While we do not wish to understate the benefits provided by CETA, we do not believe that the loss of up to $22 million CETA support resulted in a loss in services to Head Start children equivalent to $22 million.

some of the tasks that were performed by CETA workers have been assumed by current Head Start staff through reassignment and expansion of duties, while others have been assumed by volunteers. In other instances Head Start projects have accommodated themselves to CETA losses by rebudging and hiring replacement staff using their current resources. As concerns the critical area of classroom teaching staff, the FY 1982 budget provided increased funds, part of which are being used to ensure that serious problems of inadequate adult to child ratios are corrected, including replacing lost CETA classroom staff in some programs.

HEAD START/NUTRITION

Question: In fiscal year 1982 and beyond, how will Head Start programs compensate for the reductions in the child nutrition programs?

Answer: We estimate that in FY 1982 Head Start grantees will receive reimbursements for food of approximately $84 million through the USDA's Child Care Food Program. FY 1982 budget changes in the Child Care Food Program will result in a reduction of approximately $4 million in the reimbursements available to Head Start in FY 1982, as compared to FY 1981. For FY 1983, it is proposed that the Child Care Food Program be supplanted by a new General Nutrition Assistance Grant to the states which could be used for any child nutrition program or activities a state desires to fund. It is not possible to accurately predict the extent to which states may wish to continue supporting Head Start nutrition services.

To the extent which Head Start programs may lose financial support from child nutrition programs, they would have to use Head Start or new non-federal funds to maintain the required comprehensive nutrition program provided to Head Start enrollees. We expect that through a variety of improved program economies or efficiencies, savings can be found to offset any losses which may occur.

Question: How many Head Start programs and children will be affected?

Answer: Virtually all Head Start projects now participate in USDA child nutrition programs. We are not able to estimate how many, if any Head Start programs and children will be affected in FY 1983 because the availability of child nutrition funds to Head Start will depend on decisions made by each state.

Question: How will Head Start programs continue to provide nutritious meals and snacks to their children?

Answer: If part of the financial support from USDA child nutrition programs is lost, Head Start projects will achieve other economies or obtain other resources necessary to continue the comprehensive nutrition program which is an intregal part of Head Start.

INDIAN AND MIGRANT HEAD START PROGRAM

Question: How many Indian and Migrant Head Start programs are there?

Answer: The Indian and Migrant Programs Division of the Administration for Children, Youth and Families funds 94 Indian Head Start projects and 24 migrant Head Start projects?

Question: How much did they receive in fiscal 1981? In fiscal 1982? How much are they projected to receive in fiscal 1983?

Answer: On-going support for Indian and Migrant Head Start projects was $55,741,009 in FY 1981. In FY 1982, $61,962,420 is being alloted to these projects. In FY 1983, funding for these projects will increase at a rate equal to the rate of increase in the Consumer Price Index, as required by statute. We estimate FY 1983 funding will total $66,900,000.

Question: Have Indian and Migrant programs received their cost-of-living adjustments that are mandated by law, despite the lower reserve proportion and uncertain Head Start funding levels in FY 1982?

Answer: Indian and Migrant projects will receive mandated cost-of-living increases in FY 1982. These awards are currently being made. The smaller amount of funds in the Secretary's reserve, resulting from Head Start's 1981 reauthorizing legislation, does not create a problem in paying Indian and Migrant cost-of-living increases.

HEAD START PROGRAMS SPONSORED BY COMMUNITY ACTION AGENCIES

Question: What proportion of Head Start programs are currently being sponsored by community action programs (CAPs)?

Answer: Approximately 60% of Head Start grantees are CAPs.

Question: What proportion were sponsored by CAPs in FY 1981?

Answer: There has been no significant change: In FY 1981 approximately 60% of the Head Start grantee were CAPs.

Question: What effect will reduction of CAP funding and consolidation into a State community services block grant have on Head Start programs that are sponsored by CAPs?

Answer: Although further cuts in national CAA funding are proposed for FY 1983, states have the flexibility through the Community Services Block Grant to continue supporting CAA's that operate Head Start projects. We expect that Head Start will incur some additional management costs, the amount of which we cannot reliably estimate, as a result of reduced CAA funding. Regardless of funding reductions which may occur, current Head Start sponsors, including CAA's, are accorded priority in continuing as sponsors as long as they remain fiscally viable and operate sound projects. Therefore, we do not believe that changes in CAA funding or creation of the Community Services Block Grant will cause serious problems for Head Start.

Question: Are you aware of incidents involving increased demands being placed on Head Start programs by their CAP sponsors?

Answer: The demands placed on Head Start programs by their CAP sponsors are growing. Typically, demands are made on the Head Start budget to share a greater portion of administrative and indirect costs.

Question: If Head Start programs begin to seek sponsors other than CAPs, what kinds of agencies do you think will sponsor these programs?

Answer: We do not intend to seek new sponsors for Head Start projects except where current sponsors voluntarily relinquish their grant or are unable to meet fiscal and program requirements. If a CAA does need to be replaced, there is a statutory requirement that priority in the designation of a new sponsor be given to a local private or non-profit agency that has operated a Head Start program in substantially the same manner as the original sponsor. This will help minimize any disruption in program operations and help maintain the continuity of the program.

Question: What steps must a prospective new sponsor take to sponsor a Head Start program, and how long does this process take?

Answer: If there is no organization entitled to be designated as a successor agency, or no entitled agency is willing to accept the grant, we would advertise for competitive grant applications. In such circumstances the selection of a new sponsor usually takes from three to four months.

Prospective new sponsors must demonstrate that they are financially and legally viable, can operate a cost-effective and well managed program, and will continue to ensure the direct participation of parents and area residents in the program.

Question: What kinds of administrative and other costs are associated with Head Start program operation by a new sponsor?

Answer: New sponsors would incur some costs associated with developing an initial grant application. Once a grant application is negotiated and funded, administrative costs associated with the direct operation of the Head Start project can be paid from Head Start grant funds. Grantees must provide a non-federal contribution equal to 20% of total costs.

Question: How might children be affected by their Head Start program changing sponsors?

Answer: During the process of selecting a new grantee, we have usually been successful in avoiding or minimizing disruption in the operation of a Head Start program. When possible, interim sponsors are found to allow the program to remain open, or changes in sponsors are made after the end of the school year. In some unusual circumstances it is possible that operations could be disrupted for a time and children not receive services while sponsors change.

HEAD START/MEDICAID

Question: In fiscal 1981, how many Head Start children were eligible for Medicaid?

Answer: Approximately 173,000 Head Start children were enrolled in Medicaid.

Question: How many were categorically eligible?

Answer: We estimate that 138,400 eligible Head Start children were categorically eligible for Medicaid.

Question: How many were eligible by being deemed medically needy? How many of these eligible children received Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services through Medicaid?

Answer: We estimate that 34,600 Head Start children were eligible by being deemed medically needy.

Of the approximately 173,000 Head Start children who were enrolled in Medicaid/EPSDT, 81.8% received screening services paid for by Medicaid/EPSDT and 80.6% of these children who were found to be needing treatment received it through Medicaid/EPSDT funds. Also, 62.69% of the Medicaid/EPSDT enrollees received dental examinations paid for by Medicaid/EPSDT and 83% of these children who needed treatment received it through Medicaid/EPSDT. We do not have an unduplicated count which totals the Medicaid/EPSDT enrollees who received either medical or dental services through Medicaid/EPSDT.

Question: How many children received other Medicaid services?

Answer: We do not have data that differentiates between services received from EPSDT and from Medicaid.

Question: How much did these services cost?

Answer: The average annual cost per child of direct Head Start medical and dental services is estimated at $175, of which an average of roughly $100 per child was paid through Medicaid/EPSDT for eligible children. Nationally, Medicaid/EPSDT paid an estimated $17,300,000 for medical services for Head Start enrollees.

Question: In fiscal 1982 and beyond, how will Head Start programs compensate for cuts in services provided through Medicaid? How many children will be affected? How will Head Start children get the health services required by law? Who will pay for them?

Answer: If there should be cuts in services provided through Medicaid, Head Start will compensate for these cuts by linking the children with all available community health resources such as health departments, National Health Services Corps providers, Children and Youth centers and voluntary service organizations. In addition, the Head Start dollar will be used as dollar of last resort to ensure delivery of Head Start health services as mandated by law to all eligible children.

To date, the impact of restrictions in Medicaid/EPSDT have been minimal. In 1981, 34 states were extending Medicaid/EPSDT services to the medically needy in addition to children categorically eligible for EPSDT. Only one of these states has restricted the population of children eligible for EPSDT. We estimate that approximately 320 Head Start children are affected by this action, and that $32,000 in services have been lost. Additional losses, which we cannot estimate, may develop in the future.

HEAD START SALARIES

Question: In fiscal 1981, how many people working in local Head Start programs were receiving the minimum wage? How many people were working part-time?

Answer: We estimate that in FY 1981 approximately one-third of the 72,000 staff in local Head Start projects, or 24,000 employees, were paid at the minimum wage. Many more received wages that are close to the minimum wage. Approximately 27,000 staff who worked in classrooms worked and were paid for short days fo less than eight hours and sometimes for short weeks of three or four days. An additional 19,000 non-classroom staff also worked part-time. Almost all Head Start staff are on the payroll for less than 12 months a year.

Question: In states that have not received funding increases enough to match inflation, what has been the effect on wages and working hours of Head Start staff?

Answer: Under the statutory formula in effect from 1978 to 1981, some states received smaller funding increases than other states. In these states the effects on staff salaries have included some reductions in the number of hours per day or days per week for which Head Start staff are paid, limited cost-of-living increases (except when required by increases in the minimum wage), and reductions in fringe benefit contributions. We do not have data which measures the extent of these changes. Under current legislation the differences in the rate of funding increases among States are smaller or nonexistant.

Question: What was the Head Start staff turnover rate in fiscal 1982?

Answer: We do not have data on the turnover rate among Head Start staff during FY 1982. During the 1980-1981 school year, our data indicates a national average turnover rate of approximately 25%. We expect a reduction in the turnover rate by the end of FY 1982 because this year we are able to provide an estimated $32.4 million in salary increases beyond cost-of-living to selected grantees with low pay scales which contribute to high rates of turnover.

Question: What proportion of the fiscal 1982 Head Start appropriation will be used to upgrade staff salaries? What proportion of the fiscal 1983 appropriation do you expect will be used for this purpose?

Answer: In FY 1982 a funding increase of $93 million is available. We plan to use $52.9 million of this amount for cost-of-living awards to all projects to offset higher operating costs and provide staff salary increases. We expect local projects will use approximately 75% of this $52.9 million, or $39.7 million, for salary increases-75% is proportionate to local projects overall spending for personnel. In addition, selected projects with comparatively low salary levels will receive special funding increases for salary enhancement equalling approximately $32.4 million. Therefore, we expect to increase current staff wages nationally by $72.1 million in FY 1982.

In FY 1983, an estimated $3.8 million of the $ million cost-of-living funding increase for Indian and Migrant projects will be used to increase staff salaries. Aside from Indian and Migrant projects, funding increases will not be available for this purpose in FY 1983.

Question: If the Head Start program receives the revised amount of $912 million, how can enrollment levels be maintained while at the same time upgrading salaries? If one of these two objectives has to be sacrificed, which will it be?

Answer: With the exception of Indian and Migrant programs which will receive a mandated cost-of-living increase, Head Start funding will be maintained in all states at the levels provided in funding will be maintained in all states at the levels provided in FY 1982. With full FY 1982 funding available, we believe that local project managers will be able to take a variety of cost saving steps which can improve the economy an efficiency of local projects. We also plan management initiatives including cost analysis efforts, especially in projects with higher per child costs, to aid projects in reducing costs. In addition, from its beginning. Head Start has received an exceptional degree of support from volunteers and local organizations. For example, there are close to a half million volunteers annually in Head Start programs. We believe this support will continue and can be expanded. These steps combined should be sufficient to offset the marginal increase in operating costs due to inflation and to make available sufficient funds for staff to receive cost-of-living pay increase similar to those received by other public sector employees. Program quality and enrollment can then be maintained at FY 1982 levels.

CO-MINGLING OF HEAD START FUNDS

Question: During fiscal 1980, there were apparently funding problems concerning a number of Head Start programs that were operated jointly with other preschool programs. What kind of problems occurred? What has the Department done to correct them?

Answer: This is an issue raised in a report by staff of the House Appropriations Committee in February, 1980, based primarily on the situation in the State of California. In some cases in California, Head Start programs were and are co-located with early childhood programs funded by the State. Since early in 1981, we have had an agreement with the California Department of Education to ensure that Head Start funds are used to provide services only to eligible Head Start children.

We have undertaken a series of joint audits (with the State of California) to test whether there are any problems in directing or accounting for Head Start funds. These audits are now nearing the exit interview stage, and we expect to begin receiving the first results in a matter of months. If any problems are revealed by the audits, they will be dealt with promptly.

HEAD START

Question: As funding for other social programs shrinks relative to Head Start funding, what can be done to ensure that funding problems do not arise in programs that co-mingle Head Start children with other children? Should this practice be prohibited? Shoul stricter accounting procedures be required of programs that co-mingle Head Start and non-Head Start children?

Answer: Typically, agencies which receive Head Start funds plus other child-care funds use the non-Head Start money to extend services (as in increasing the length of the day with the use of Title XX Day Care funds) or to provide Head Start-type services to more children (as in the case of

California, Alaska, and Washington, all of which appropriate State money for child development programs or specifically for Head Start). This is an economical practice, one which so far as we know allows each program to accomplish more than could be accomplished if the funds were not merged at the service delivery level. For that reasons, the practice should not be prohibited. We have instituted safeguards in California to ensure that Head Start funds only support Head Start eligible children in programs which meet or exceed the Congressionally required program performance standards for Head Start.

The joint audits now nearing completion in California are expected to tell us whether stricter accounting procedures are needed. In addition, Head Start will be moving to institutional audits, in which all the grant income, no matter what the source, is audited at the same time. Institutional audits are being required by OMB partly for the purpose of tracking the use and allocation of all government money which flows to a single grantee.

HEAD START COST REDUCTION PROPOSALS

Question: Please elaborate on the October 30, 1981, proposals to reduce Head Start costs. Describe the effect of these proposals on local Head Start programs. Describe the effect of these proposals on operatin of the National Head Start Program here in Washington.

Answer: The October 30, 1981 proposals to reduce Head Start costs were part of an overall Head Start Strategy Paper which explored options for improving Head Start services, for accommodating the effects of inflation and reductions in other Federal program expenditures, for reducing the reporting and regulatory burden on local communities, and for containing Head Start costs. While not an incidental element of the Strategy Paper, cost containment was not its principal focus. At the time the paper was written, the budget proposed for Head Start for FY 1982 was $835 million. Since the Congress has approved a level for FY 1982 of $911.7 million in the continuing resolution, these cost containment options have become less crucial, and the Department has considerably more flexibility.

The options in the Strategy Paper have been widely discussed and debated within the Head Start community, and many of the proposals, including those which had to do with examining local program budgets to identify further economies, met with general approval in the many thoughtful comments which were returned to the Department. Those issues in the Strategy paper on which public opinion was divided are now being reviewed by the Assistant Secretary for Human Development Services and the Secretary before final decisions are made. Those aspects of the Paper which could be described as cost-reduction proposals are essentially settled, and to the extent there is any effect on local Head Start programs it will be a salutary one. The effects on the operation of the National Head Start program in Washington will also be salutary. This is because, partly as a result of the debate surrounding the Strategy Paper, Head Start will establish a special management objective to assist local programs in identifying opportunities for cost savings and greater economy, so they can better serve their communities with the available Federal funds. We will also be assisting local programs in their efforts to make greater use of volunteers and other local resources.

Question: Was the October 30, 1981, document intended to be a draft of proposed regulations? Of proposed administrative guidelines for local programs? How can these proposals be implemented and by whose authority? Are plans to consult with Congress about these proposals?

Answer: The October 30, 1981 Head Start Strategy Paper was not intended as a draft of proposed regulations or of administrative guidelines. It was intended-- and has served --as a discussion document for engaging the Head Start community in an effort to improve the program over the period provided by Congress in the 1981 reauthorizations. The options discussed in the paper could be implemented by regulation or by administrative directive. The Head Start Strategy Paper was widely distributed, including copies which were provided in response to requests from various Congressional offices. We have had useful discussions regarding various issues raised in the paper with a number of Congressional staff. The paper was a central focus in a hearing of the House Education and Labor Sub-Committee on February 23, 1982.

Question: How do you intend to respond to the Public Comments you solicited on your October 30, 1981, proposal to reduce Head Start costs?

Answer: All of those who commented on the Head Start Strategy Paper have already received a reply, thanking them for their comments and assuring them that ACYF will give careful consideration to their comments. No further response to the public is planned, except that as decisions are made on Strategy Paper options which affect local programs, the Head Start community will be fully informed through our normal channels of communication.

Question: What other approaches besides those outlined in the October 30, 1981, proposal, are being considered to reduce Head Start costs?

Answer: The principle cost control effort in Head Start for fiscal years 1982 and 1983 is the effort on the part of Regional Offices to work with local programs at the time they are preparing their grant application. We will be working with them to identify potential economies, to seek alternatives to the most costly or most inflation-sensitive items in their budgets, and to pass on money saving ideas generated by other Head Start programs. We will be working especially with those local programs which will be identified, through cost analysis techniques, as candidates for cost saving opportunities.

HEAD START ALLOCATION FORMULA

Question: How is the new Head Start allocation formula working?

Answer: The new statutory allocation formula is working well. It is sufficiently flexible to allow us to carry out the objectives of FY 1982 budget. It enables all states to receive a share of increased funds, thereby helping to maintain current levels of services in all states. The only potential problem we foresee is that the mandated cost-of-living increases for Indian and Migrant projects could considerably reduce the funds available for training, technical assistance, and research, evaluation and demonstration activities, if the total Head Start appropriation was the same for several years.

Question: In light of the uncertain funding situation so far in fiscal 1982, has the new State allocation formula been able to solve the problems inherent in the old formula?

Answer: The uncertain funding situation which existed in the first quarter of FY 1982 was not affected by the new statutory formula. During that period, proejcts were refundedat the FY 1981 levels. We are now awarding grants that reflect the higher FY 1982 budget of $911.7 million.

The new formula has solved problems which were felt by Congress to exist under the old formula. Specifically, the restrictions in the growth of funding which were applied to a number of states have been removed. These restrictions made it difficult for these states to maintain existing levels of enrollment and quality.

Question: Has the new State allocation formula enabled any States to increase Head Start participation in the fiscal 1982?

Answer: Yes it has. While we do not have all the figures at this time, there are states such as Illinois that will experience some enrollment increases in 1982.

HEAD START RESERVE FUNDS

Question: Please describe the allocation of Head Start reserve funds in fiscal 1981. Please describe the proposed allocation of reserve funds in fiscal 1982 and in fiscal 1983.

Answer: Enclosed for the record is a table that shows the use of funds in the Secretary's reserve in FY 1981 and the planned uses for FY 1982 and FY 1983.

	FY 1981	FY 1982	FY 1983
	(dollars in thousands)		
o Indian and Migrant Projects	$55,741	$61,962	$66,900
o Project in Territories	*	4,084	4,084
o Supplements to local projects	21,800	12,775	12,576
o Training & technical assitance	27,400	27,400	27,400

	FY 1981	FY 1982	FY 1983
	(dollars in thousands)		
o Research & Demonstration	10,200	9,600	5,400
o Evaluation	4,400	2,700	2,200
	$119,541	$118,521	$118,560

*Not funded from Reserve under 1978 statute.

Question: What has been the effect of lowering the proportion of the Head Start appropriation that is reserved by the Secretary?

Answer: In terms of the actual way in which funds are used, the reduction of the proportion of the appropriation which is reserved for the Secretary has had no effect. Although less funds are available to add as supplements, to state allotments, states receive larger statutory increases. Given the budget policy which was agreed to, total funding to states would, in FY 1982, have been the same under both the old and new legislation. (The distribution of funds among states would have been slightly different.) Sufficient funds remain available under the new formula to support T/TA and RD&E at desired levels.

DEPARTMENTAL MANAGEMENT

STATEMENT OF DALE W. SOPPER, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

ACCOMPANIED BY:
ROBERT J. RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
RICHARD P. KUSSEROW, INSPECTOR GENERAL
A. PRENTICE BARNES, CHIEF, FORMULATION BRANCH, DIVISION OF OFFICE OF THE SECRETARY BUDGET SERVICES
BETTY LOU DOTSON, DIRECTOR, OFFICE FOR CIVIL RIGHTS

SUBCOMMITTEE PROCEDURE

Senator RUDMAN. We will call now on Mr. Dale W. Sopper, Assistant Secretary for Management and Budget testifying on Departmental Management Activities.

Mr. Sopper, if you would like to proceed with a summary of your statement, your entire statement will be incorporated in the record.

INTRODUCTION OF ASSOCIATES

Mr. SOPPER. Thank you, Mr. Chairman.

If I may, before beginning my summation, I would like to introduce my colleagues.

On my left is Dr. Robert Rubin. He is the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services.

On Dr. Rubin's left is Richard Kusserow. Mr. Kusserow is the Inspector General, Department of Health and Human Services.

On my right is Mr. A. Prentice Barnes. He is the Chief of the Budget Formulation Division for the Office of the Secretary.

And on Mr. Barnes' right is Ms. Betty Lou Dotson. She is Director of the Office for Civil Rights.

SUMMARY OF STATEMENT

I am pleased to be here today, Mr. Chairman, to present the fiscal year 1983 departmental management portion of the HHS budget request. In light of the time of day, I will try to be as brief as possible to allow time for your questions.

Departmental management is made up of five appropriations, four of which are considered by this committee—general departmental management, the Office of Inspector General, the Office for Civil Rights, and policy research.

The resources for these appropriations support a spectrum of activities. General departmental management enables the Secretary to manage the Department efficiently and to provide major operational services to the entire Department on a centralized, efficient basis.

The Office of Inspector General identifies actual and potential fraud, waste and abuse, and makes recommendations to avoid misfeasance of funds.

The Office for Civil Rights has responsibilities for enforcing the nondiscrimination laws in HHS programs.

And policy research conducts research in alternative policies in our health, social services, and welfare programs.

The fiscal year 1983 departmental management request includes funding of $281.5 million in obligational authority of which $16.4 million is from transfers from social security and health insurance trust funds for services performed on behalf of benefit programs financed by the trust funds.

This request amounts to a total increase of $14.6 million in budget authority over fiscal year 1982. Almost all of the $14.6 million is necessary to support built-in cost-of-living increases.

The fiscal year 1983 request includes staffing of 5,390 full-time permanent positions, 284 less than fiscal year 1982.

We believe the fiscal year 1983 departmental management request of $281.5 million, which is 5 percent above the fiscal year 1982 CR will continue the reductions of these accounts in real terms and further the administration's objective of reducing the growth in the Federal Government while still providing sufficient resources to improve departmental management controls and procedures for increased efficiency.

For example, the general departmental management activity is requesting $167 million in obligational authority, including a trust fund transfer of $8 million and 3,538 positions, a reduction of 284 from fiscal 1982.

As you know, general departmental management is organized into two major activities—departmental direction, which are those activities that reflect the policy and general administrative and personnel management role of the Secretary, and departmental operations, those activities reflecting the administrative service/operations role of the Secretary.

Of the 284-position reduction, 80 are taken from direction activities, a 6-percent reduction below fiscal year 1982, and 204 are taken from operations, an 8-percent reduction below fiscal year 1982.

The bulk of the 284-position reduction occurs in departmental operations essentially due to decreased workloads resulting from the restructuring of the Department's programs.

The Office of Inspector General, the Office for Civil Rights, and policy research are requesting a current services level of effort for fiscal year 1983 of $72.2 million in budget authority and 1,026 positions for the Office of Inspector General, $19.2 million in budget authority, and 524 positions for OCR, and $14.7 million and 15 positions for policy research.

It should be noted that the fiscal year 1982 column of the fiscal year 1983 departmental management budget request does not include funding for the October 1981, pay raise or the January 1982, lifting of the executive pay cap. OMB will be reviewing the Department's request for a pay raise supplemental within a month and has indicated its intention to submit any necessary pay raise supplemental to Congress after March.

In conclusion, Mr. Chairman, I believe this is an austere, realistic budget that provides sufficient resources to carry out the national responsibilities of the Secretary.

Thank you.

Senator RUDMAN. Thank you very much, Mr. Sopper.

Are there any other people at the witness table who have statements?

Mr. SOPPER. No, sir.

OFFICE OF GENERAL COUNSEL

Senator RUDMAN. Before we get into a general line of questioning, am I correct in assuming that the General Counsel's Office reports to you?

Mr. SOPPER. The Office of the General Counsel reports directly to the Secretary. It is a staff division within the Office of the Secretary.

Senator RUDMAN. So you have no line authority over them whatsoever?

Mr. SOPPER. No, I do not direct the general counsel. He receives his direction from the Secretary as do I. I do have responsibilities to provide some administrative functions as head of the operating division called the Office of the Secretary. This is not direction in the sense of directing him to work. I assure performance of administrative and personnel services for the Office of General Counsel.

We do have an organization chart which, if it would be helpful, we could have entered into the record which shows how the Office of the Secretary is organized.

Senator RUDMAN. I believe I have seen it, but I for some reason thought perhaps the General Counsel's Office was more under your direction——

Mr. SOPPER. No, sir.

Senator RUDMAN [continuing]. Day-to-day than the Secretary.

Mr. SOPPER. No, sir.

GENERAL DEPARTMENTAL MANAGEMENT REQUEST

Senator RUDMAN. The general departmental management function supports two basic categories—those closely associated with the Secretary's role as a policy officer, and general department manager, and then all those specialized staff services which are performed, of course, for the principal operating divisions of the Department, with some degree of centralization.

Can you tell us, is it absolutely necessary for your request to be up $18 million for this section over 1982?

Mr. SOPPER. We are requesting in fiscal year 1983 $17,412,000 for cost-of-living increases or built-ins for general departmental management. These items are broken out as follows, Mr. Chairman:

For pay costs, we have $8,720,000. And I might add that this is the amount necessary in fiscal 1983 to fund the full amount of the October 1981, pay raise and the lifting of the executive pay cap. This increase appears to be quite large because no funds are included that are needed in fiscal 1982 for the purposes of meeting the increased fiscal year 1982 pay costs.

There is an increase of $7,187,000 for space building management. There is an increase in telephone rates of $615,000; freight shipment rates, $17,000; postage rates, $113,000; and other administrative costs increases—such as ADP, printing, supplies, and equipment of $760,000—making the total built-in cost increase of $17,412,000.

GENERAL DEPARTMENTAL MANAGEMENT POSITION REDUCTIONS

Senator RUDMAN. Of the 284 terminations in fiscal year 1982, how many of those have been made from field staff and how many from headquarters?

Mr. SOPPER. In terms of the reductions which are proposed for fiscal year 1983, 80 of the positions come from the departmental direction part of the general departmental management appropriation. Those are broken out as follows: There are 14 positions being reduced from planning and evaluation; 13 positions eliminated from personnel administration; and 53 field management positions being abolished. These 53 are being reduced from the policy direction part of regional office operations.

Under departmental operations, there are 204 positions which are being reduced as follows: 16 in facilities engineering; 106 in regional services—that activity which includes such things as accounting activities, personnel, that type of thing; employee systems center, 24; and legal services, 58.

So between the 80 and the 204 a total of 284 position are being eliminated.

Senator RUDMAN. Do you think the reductions have been relatively proportionate or disproportionate between the headquarters here and the field?

Mr. SOPPER. Of the reductions there are 6 percent in the headquarters and 8 percent are in the field. I think that is a fairly proportional reduction. I think it is an appropriate one.

BLOCK GRANT IMPACT ON GENERAL DEPARTMENT MANAGEMENT

Senator RUDMAN. Could you tell us to what extent block grants resulted in less money being lost in management inefficiency and assistance problems during the past year? That is hard to quantify, but I am just asking for your impression.

Mr. SOPPER. Well, my feeling is that we are still in an early stage of knowing exactly what is happening out there in the States. We expect to get the results of a very preliminary GAO report in the later part of March on how the States are operating with block grants.

We are hopeful that the block grants will allow the States to operate much more efficiently in terms of their own State management. But as

I indicated, we are still waiting to see the results of the preliminary evaluation data that is going to be coming in.

CONSULTANT SERVICES

Senator RUDMAN. Certainly, that would be helpful to us.

Roughly, departmental needs for increases of people at the departmental level if block grants work as they are supposed to.

What percentage of your budget is projected to be used for consultants in fiscal 1983, and how does that compare with fiscal year 1982?

Mr. SOPPER. Are you asking the overall Department amounts for consultants, the total amount or just——

Senator RUDMAN. General departmental amount.

Mr. SOPPER [continuing]. For consultant services in fiscal year 1983, we are requesting in departmental management $5.1 million in budget authority combined with $8.2 million in funds to be reimbursed to departmental management from the operating programs for services rendered. So that it would be a total obligational authority of $13.3 million for consultant services.

Senator RUDMAN. For fiscal year 1983?

Mr. SOPPER. 1983.

Senator RUDMAN. How does that compare to 1982?

Mr. SOPPER. It is an increase from fiscal 1982 of 16 percent. The amount in fiscal 1982 was $11,505,000. I would note that the largest increase here occurs in the Office of the Inspector General where we have increased from fiscal year 1982 the amount that was available for contract audit services from $2.3 to $4 million in fiscal 1983.

These contracts permit the Office of Inspector General to expand the coverage of his annual audit program without diverting the in-house staff from ongoing and new initiatives.

Mr. KUSSEROW. If I may add, Mr. Chairman, that money is essential to restore the approved level of contract audit effort but which we cut back in the last fiscal year because we had insufficient resources to support our onboard staff salaries and expenses. So that last year was far lower than it had been running in the previous years.

What we are asking for here is a restoration of the previous level so that we can have the closeout audits of the intermediaries, amounting to around $1 billion in backlog, cleared up by just contract auditors.

OFFICE OF INSPECTOR GENERAL

Senator RUDMAN. Let's turn to a few questions on the Office of Inspector General.

Last year, the OIG estimated losses of the Department due to fraud, waste, and abuse, of $5.5 billion. What is the comparable estimate of the current losses, and what action is being taken beyond what you have already described?

Mr. SOPPER. Well, as you know, Mr. Chairman, the estimate of the $5.5 to the $6.5 billion was the reestimate from the original Inspector General's report that was submitted in 1978. And of the IG's fiscal year 1977 total estimate of $5.5 to $6.5 billion, the Inspector General indicated that the Department could begin to attack approximately $2.7 billion or about 50 percent of this amount under existing resources. After the IG issued this report in March 1978, we established a high-priority program to document savings resulting from efforts to reduce management inefficiencies, fraud, and abuse.

In fiscal year 1979, the Department, including education programs, achieved savings of $1.4 billion, exceeding the goal for that year of $1.3 billion. These savings resulted from activities such as reducing erroneous payments, implementing limits for medicare reimbursement, increasing program audits, and recovering overpayments.

For fiscal year 1981, we have documented savings to date of $660 million. We are currently earmarked in fiscal year 1982 to achieve savings of approximately $2.6 billion. And our preliminary estimates for fiscal 1983 savings are approximately $3 billion.

All these savings estimates use the Inspector General's fiscal year 1978 report as the base.

Mr. KUSSEROW. Which included at that time the now Office of Education or Department of Education, which has since been taken out of the Department.

FRAUD, ABUSE, AND WASTE MINIMIZATION EFFORTS

Senator RUDMAN. Can you tell me what the role is of the Inspector General or will be in assisting the States and localities in minimizing fraud and abuse in administration of health programs under the block-grant approach?

Mr. KUSSEROW. It is still difficult to really assess, but the primary vehicle for that is the State medicaid fraud control units programs. Units are set up in 29 States, currently, and are dedicated to carrying out fraud investigations. As you know, implementation and oversight of the State medicaid fraud control unit program is supported by the funding in our office.

So that has become a major vehicle in that area.

In addition to that, we are organized internally to include a State fraud division to coordinate and develop liaison between these State units and the Federal Government. This is important because in many of the programs we have a concurrent Federal and State interest. In addition, this liaison is important in instances where a State is proceeding on a prosecution and may not have in their individual State a State false-claim statute. We can be of assistance here because in Federal laws we do have that statute.

So you could have this situation: A criminal prosecution by the State and a followup civil prosecution by the Federal Office of Investigation. We could coordinate better there.

We also feel that we can coordinate better at multiple-jurisdictional investigations involving several States to assist them in the procedures that would normally encumber them in their investigation.

So there are a wide variety of initiatives we are trying to innovate this coming year along that line.

Senator RUDMAN. I would think that would be a very essential activity because, obviously, once these block grants are really moving, then if the accompanying oversight doesn't move with it in some way all that you have achieved would be reversed. The States must have the proper guidance and the techniques to do the kinds of work that you do.

Mr. KUSSEROW. Particularly in the health provider area where we are very concerned also from our audit side, and we are devoting a greatly enlarged percentage of our resources to look at, especially in medicare, the hospital-based system that exists out there, and then also in medicaid—the long-term care system that is operating there—so we can better understand the factors that are working on it, driving the costs up in these programs, and also to try to identify those areas in which we can provide some guidance and some assistance and some advisement to the Congress as to what opportunities might be there to make those programs run more efficiently as well as to the Department in the form of regulatory action.

CIVIL RIGHTS ENFORCEMENT

Senator RUDMAN. We will turn briefly to the Office of Civil Rights.

In your prepared statement, you discussed outreach efforts and the importance of providing State officials with the information and guidance they need to assume a more active role in assuring the compliance of programs funded under block grants.

How much of your budget is geared toward these efforts and to what extent does the Department anticipate the program would be run by the States?

Mr. SOPPER. Ms. Dotson?

Ms. DOTSON. At this time, Mr. Chairman, we are working ou' methodologies to work with the States to get an indication from them as to just how actively they can become involved in compliance activities.

As you know, under the block-grant legislation, when a finding of noncompliance is made, it is necessary that we give the Governor 60 days to do something about it. To this date, we have not been receiving many complaints directly related to program delivery under the block grants.

So we at this point do not have a good feel as to how it is going to work out with the States because there are varying degrees of capabilities and capacities within the States to take care of some of the functions which are associated with the nondiscrimination requirements.

PREPARED STATEMENTS AND SUBMITTED QUESTIONS

Senator RUDMAN. Thank you very much.

Mr. Sopper, we have a great deal of additional questions, some of which I expect will take some time to answer. So we are going to have you answer those for the record.

I just want to close by saying to you that although you have no supervisory control over the legal staff down there, you do have some say in their budget requests, I submit.

Mr. SOPPER. That's true, Mr. Chairman, yes.

Senator RUDMAN. And I believe you were in the room when I had my dialog with Mr. Trachtenberg, were you not?

Mr. SOPPER. No, I was not present then, Mr. Chairman.

Senator RUDMAN. Well, why don't you talk to Mr. Trachtenberg?

Mr. SOPPER. I will, Senator, and I will read the record.

Senator RUDMAN. He might describe it as a monolog; I prefer to consider it a dialog.

But I am very concerned about the way a particular incident was handled. I just think it is unnecessary for people who know our—we have very nice staff and very friendly people. They answer their telephone calls. They are very anxious to please, to be helpful.

And they certainly ought to be called when a serious question arises as to language that we carefully drafted before some lawyer who doesn't understand or take the time to look through the legislative history makes a decision which causes a lot of people a great deal of grief.

And I will tell you this: If I saw it happen much more, I think I would find someplace to handle it rather directly myself.

I hope you get that message back there, too.

Thank you very much.

Mr. SOPPER. All right, Mr. Chairman.

[The statements and the following questions which were not asked at the hearing but were submitted for response for the record follow:]

STATEMENT OF DALE W. SOPPER

I am pleased to be here today and have the opportunity to present and justify the FY 1983 Departmental Management portion of the Department of Health and Human Services budget request. As you know, Departmental Management is made up of five appropriations, four of which--General Departmental Management (GDM), Office of the Inspector General (OIG), Office for Civil Rights (OCR), and Policy Research (PR)--are considered by this Committee. Within the resources of these appropriations, the Secretary manages the entire Department; provides major operational services to the entire Department on a centralized, efficient basis; identifies actual and potential instances of fraud, waste and abuse and makes recommendations to avoid mis-utilization of HHS funds; fulfills responsibilities for enforcing the nondiscrimination laws in HHS programs; and provides for research into alternative policies in our health, social service, and welfare programs.

Our budget request in FY 1983 totals $265.1 million along with 5,390 full-time permanent positions, 284 less than were authorized in FY 1982. In addition to the $265.1 million in budget authority, we are also requesting a transfer of $16.4 million from the Social Security and Health Insurance trust funds to cover costs of services provided by GDM, OIG, and OCR on behalf of benefit programs financed by the trust funds. Thus the total obligational authority for the FY 1983 request is $281.5 million. We are also requesting $10 million as advance appropriations for FY 1984 to support first quarter costs of the OIG State Medicaid Fraud Control Unit entitlement program.

General Departmental Management

The shape, direction and composition of the Federal budget are undergoing dramatic change under this Administration. Of all government departments HHS has perhaps the most responsibility for planning, developing and then implementing significant portions of these changes as they are approved by the Congress. One consequence of this activity is a notable increase in the level of workload for the policy development, budget, and legislative function included in the appropriation. In order to fulfill these responsibilities and maintain priority on-going activities, the Secretary requires [illegible] million and 3,538 positions in FY 1983, including trust fund transfers.

Before discussing the GDM budget request further, I would like to outline the activities conducted by the Secretary under this appropriation. This appropriation is organized into two major activities -- Departmental Direction and Departmental Operations:

-- Departmental Direction supports those activities related to the Secretary's responsibilities for the management of the Department, such as financial management, budget formulation, personnel management, grants and contracts management, policy analysis, and legal work affecting the Department in general.

-- Departmental Operations supports six major services whose work results directly from agency program operations. These include: legal services provided to all of the Department's program agencies; facilities engineering, which oversees all facilities operations within the Department; administrative services provided Department-wide headquarters staff; the Grants Payment System that serves as a central departmental payment and cash control point for recipients of grant and contract awards; regional administrative services provided to the Department's regional program components; and central payroll and personnel data services provided for all departmental employees.

Of the total increase over FY 1982 of $17.9 million in this account, $17.4 million is for non-controllable, built-in cost increases including $7.2 million for GSA rental-rate increases in office space and building management services, and $8.7 million for increased pay costs related to the October 1981 pay raise which is not yet included in the 1982 column of the budget. We have no ability to absorb these non-discretionary increases in FY 1983 without a further reduction in staff, below the already reduced level reflected in this request.

We are also requesting funds for four low-cost program improvements totalling $1.7 million, which, when combined with other program changes, will increase operating efficiency and reduce our staffing needs.

Specifically, these improvements are as follows:

- The expansion and improvement of a document control tracking system in the Office of the Secretary and Under Secretary and participating operating divisions of the Department.
- Maintenance of the scheduled implementation and extension of the Standard Accounting System to other parts of HHS.
- Implementation of the Department's Payments Management Systems (PMS), which corrects the cited deficiencies of our old Departmental Federal Assistance Financing System (DFAFS) and enables HHS to implement the Treasury's Financial Communications System at a savings of up to $18 million per year in Federal interest costs.
- Upgrading the HHS Personnel and Payroll System to correct cited deficiencies.

Office of the Inspector General

To continue the essential work of the Office of the Inspector General, the budget proposal includes $72.2 million, an increase of $3.3 million above the FY 1982 level. This level of funding will support 1,026 full-time permanent positions, the same number as FY 1982.

In addition to $72.2 million in budget authority, we are also requesting a transfer of $6.0 million from the Social Security and Health Insurance trust funds to cover costs of services provided by OIG on behalf of benefit programs financed by the trust funds.

In FY 1983, the OIG will concentrate its efforts towards identifying the processes in the Department's programs which give rise to opportunities for fraud, waste and abuse. This contrasts with the OIG's previous exclusive emphasis on financial findings and criminal investigations. Specifically, the new emphasis for audit and reviews will be directed towards Social Security, Health Care Financing, and internal management controls.

In the area of investigations, while priority will continue on criminal fraud, non-criminal sanctions such as civil recoveries and administrative and debarment activities will be given greater emphasis.

Office for Civil Rights

To support the Office for Civil Rights (OCR), we are requesting $19.2 million in budget authority and 524 full-time permanent positions. In addition, $2.4 million will be transferred from Social Security trust funds.

The fiscal year 1983 request would maintain OCR at the same operating level as in FY 1982. No program increase is requested. The additional amount of $2.1 million requested for fiscal year 1983 represents built-in, cost of living increases, including funds associated with the pay raise and the January 1982 lifting of the executive pay cap.

OCR is the principal agency responsible for enforcing the non-discrimination laws in health and human services programs. These laws prohibit discrimination on the basis of race, color, national origin, handicap, and age. There are about 165,000 insitutional providers subject to the civil rights laws. OCR's responsibility is to ensure that all recipients of Department funds are aware of their civil rights obligations and have taken the necessary steps to comply.

Policy Research

The FY 1983 requested funding level for Policy Research of $14.7 million will support important on-going research activities in the areas of health, income and employment, and social services policy. This research is valuable in that it provides information to the Department and the Administration, the Congress, and other policymakers on current and proposed Departmental programs and the anticipated effects of changes in these programs.

Summary

In conclusion, Mr. Chairman, I believe that this is an austere but realistic budget that provides sufficient resources to carry out the array of national responsibilities levied upon HHS Departmental management. I urge your approval of this request and thank you for your consideration.

I am pleased to be with you today to present the FY 1983 budget request for the General Departmental Management appropriation of the Department of Health and Human Services.

The shape, direction and composition of the Federal budget are undergoing dramatic change under this Administration. Of all government departments, HHS has perhaps the most responsibility for planning, developing and then implementing significant portions of these initiatives as they are approved by the Congress. One consequence of this activity is a notable increase in the level of workload for the policy development, budget, legislative, and legal functions included in this appropriation. In order to fulfill these responsibilities and maintain priority on-going activities, we are requesting $159.0 million and 3,538 positions in FY 1983.

In addition to $159.0 million in budget authority, we are also requesting a transfer of $8.0 million from the Social Security and Health Insurance trust funds to cover costs of services provided by General Departmental Management on behalf of benefit programs financed by the trust funds. Thus the total obligational level for the FY 1983 request is $167.0 million.

Of the total increase of $17.9 million in this account, $17.4 million is for non-controllable, built-in cost increases including $7.2 million for GSA rental rate increases in office space and building management services; $8.7 million for increased pay costs related to the October 1981 pay raise which is not yet included in the 1982 column of the budget; $.6 million for increased telephone costs reflecting recent events in communications rate structures; and $.9 million for increases in other administrative costs such as postage and freight rates, rentals, printing, equipment, and supplies. We have no ability to absorb these non-discretionary increases in FY 1983 without a further reduction in staff, below the already reduced level reflected in this request.

We are also requesting funds for four low-cost program improvements totalling $1.7 million, which, when combined with other program changes, will increase operating efficiency and reduce our staffing needs.

Before discussing the budget request further, I would like to outline the activities conducted by the Secretary under this appropriation. This appropriation is organized into two major activities -- Departmental Direction and Departmental Operations:

-- Departmental Direction supports those activities related to the Secretary's responsibilities for the management of the Department, such as financial management, budget formulation, personnel management, grants and contracts management, policy analysis, and legal work affecting the Department in general.

-- Departmental Operations supports six major services whose work results directly from agency program operations. These include: legal services provided to all of the Department's program agencies; facilities engineering, which oversees all facilities operations within the Department; administrative services provided to Department-wide headquarters staffs; the Grants Payment System that serves as a central departmental payment and cash control point for recipients of HHS grant and contract awards; regional administrative services provided to the Department's regional program components; and central payroll and personnel data services provided by the Employee Systems Center for all departmental employees.

As mentioned earlier this request includes modest costs for program improvements aimed essentially at raising staff operating efficiencies through introduction and improvement of ADP processing applications and equipment. These improvements require no additional staff to implement.

Specifically, these improvements are as follows:

Document Control Tracking System

- The expansion and improvement of a document control tracking system in the Office of the Secretary and Under Secretary and participating operating divisions of the Department which will track correspondence, regulations, internal memoranda and other documents throughout the Department through a single system, thereby increasing efficiency and reducing the turnaround time involved ($152,000).

Standard Accounting System

- Maintenance of the scheduled implementation and extension of the Standard Accounting System to other parts of HHS. Implementation of this system would result in cost avoidance of $325,000 in FY 1984 - 1985 ($203,000).

Payments Management System

- Provision of ADP processing support for the operation of the Department's Payments Management System (PMS), which supercedes our old Departmental Federal Assistance Financing System and will better enable us to control excess cost and make more timely and accurate payments to our grantees ($410,000).

Personnel and Payroll Systems

- Upgrading the HHS Personnel and Payroll Systems to correct deficiencies cited by the HHS Inspector General, to continue implementation of the Civil Service Reform Act, and to upgrade the Department's integrated payroll/personnel system ($928,000).

Program Reductions

Consistent with the Administration's policy of reducing Federal staffing, this request reduces Departmental direction staff by 80 positions and Departmental operations staff by 204 positions, continuing the reduction in staff initiated last year.

The departmental direction staffing decrease of 80 positions reflects both the changing relationship the Department has with with State, local and other recipients of resources combined with planned conversion of staff from workloads of lesser importance to initiatives critical to the Administration, i.e., creating broadened and more effective block grant programs, reducing fraud and waste in HHS programs, and improving debt management collection.

The departmental operations staff decrease of 204 positions reflects reduced levels of support activities required by the Department's operating divisions principally in regional offices, and increased operating efficiencies due partially to introduction and improvement of automated data processing applications and equipment.

Summary

In conclusion, Mr. Chairman, I believe that this is an austere but realistic budget that provides sufficient resources to carry out the array of national responsibilities levied upon the Department. I urge your approval of this request and thank you for your consideration.

BIOGRAPHICAL SKETCH

Dale W. Sopper was sworn in as assistant secretary for management and budget, Department of Health and Human Services, Sept. 24, 1981. He had been the acting assistant secretary since June 27, 1981, and from January 1981 to June 1981 had served as acting assistant secretary for legislation.

Before that Sopper, who has been with the department and its predecessor, the Department of Health, Education, and Welfare, since 1965, was director of program coordination in the Office of the Assistant Secretary for Legislation from July 1978 to January 1981.

He is the HHS Secretary's principal advisor for management, administrative and budget policies His responsibilities include overseeing development of the department's budget and providing department-wide guidance on general management operations and major policies in HHS in such areas as grants, contracts, financial management and automatic data processing systems.

Sopper was born in Allentown, Pa., Dec. 24, 1941. He received his bachelor's degree, with honors, from Lehigh University, Bethelehem, Pa., in June 1963, and did graduate study at the University of Minnesota from June 1963 to June 1965.

He joined the department in July 1965 as a claims insurance specialist with the Social Security Administration's Office in Kansas City, Mo. From July 1967 to November 1969, he was a management intern for SSA and had assignments as a financial systems analyst in the Office of the Assistant Secretary for Community and Field Services and as staff assistant in the Office of the Assistant Secretary for Health and Scientific Affairs. He served in the latter office as a management analyst from November 1969 to April 1972.

Sopper started in the Office of the Assistant Secretary for Legislation in April 1972 as a special assistant for health legislation. He became legislative officer for health in May 1973, senior agency legislative officer in July 1974, was acting deputy assistant secretary from April 1975 to January 1976 and served the first of his two stints as acting assistant secretary for legislation between January 1977 and April 1977.

Sopper has had a distinguished career in the department, receiving several honors for his performance: Distinguished Service Award, March 1980; Secretary's Letter of Commendation, August 1979; Secretary's Special Citation, August 1975; and the Superior Service Award, December 1974.

Sopper is married, has two daughters and resides in Reston, Va.

Sept. 24, 1981

STATEMENT OF RICHARD P. KUSSEROW

I am pleased to appear before you today for the first time to discuss the President's FY 1983 budget proposals for the Office of Inspector General. This budget totals $72,240,000, an increase of $3,329,000 above the FY 1982 level. This level of funding will support 1,026 full-time permanent positions, the same number as FY 1982, 40 staff years of effort from other than full-time permanent employees, and 80 staff years of non-Federal contract auditors.

In addition to $72,240,000 in budget authority, we are also requesting a transfer of $6,000,000 from the Social Security and Health Insurance trust funds to cover costs of services provided by OIG on behalf of benefit programs financed by the trust funds. Thus, the total obligational level of the FY 1983 budget is $78,240,000.

One significant change in this year's budget presentation, pertaining to the funding of State Medicaid Fraud Control Units, is that we have eliminated the request for last quarter borrowing authority and substituted a request for $10 million in advance appropriations. This change conforms to government-wide practice and will make funding of SMFCU consistent with funding of the Medicaid and Assistance Payments accounts.

During almost five years of operations, the Office of Inspector General has enjoyed the strong support of your committee. As a result, the office has made substantial contributions to the Department's progress in reducing fraud, abuse and waste in programs administered by the Department of Health and Human Services. The budget document before you indicates the new direction and priority of the OIG; direction and emphasis which are the healthy offspring of those earlier accomplishments and yet ensuring that OIG priorities are current with in-place program and management needs.

I was appointed as the Inspector General for the Department of HHS on June 10, 1981. Since that time I spent as much time as possible studying the organization, its mission, priorities, and strengths and weaknesses. This analysis of the past and observation of the current operations I believe, allowed me a clear perspective of what needed to be done.

In the past, each of the operating components of the Office of Inspector General had individual work planning processes.

It quickly became clear to me that what was needed was not three separate plans but one overall coordinated plan. This year marks the first time that these individual planning processes have been integrated into a comprehensive OIG plan. This is the first step in developing a long-range (multi-year) plan.

The purpose of this plan is to describe the goals and policy directions we wish to take. It also provides some general strategy to achieve the objectives.

In many ways our efforts for 1982 and 1983 reflect different assumptions from the past and as a result, require shifts in priorities for the future. We believe these shifts not only will bring greater savings to the Department but can be accomplished with existing resources being directed to more appropriate tasks.

One of the OIG's principal roles is to act as an "Agent for Change" within the Department of Health and Human Services. Previously there had been a heavy accent on focusing on financial findings and criminal prosecutions as the determinant of success. We are now directing much of our efforts to identify the processes which give rise to opportunities for fraud, waste and abuse in our programs. What I want to do is somewhat analogous to a physician who avoids treating the symptom, but instead uses the symptom to identify the disease. Thus with our new efforts we hope to provide management with information through which the programs can be made more efficient or cost effective. Therefore, more management efficiency and accomplishment audits and reviews will be performed. This will enable those funds that have been lost to fraud, abuse and waste to reach the recipients for whom they were intended.

Past efforts by our auditors were guided by OMB requirements that they act as the cognizant agency for the entire Federal Government in reviewing over 5,000 university and non-profit agencies, and for State and local cost allocation plans. They also were mandated to respond to Federal procurement regulations by conducting numerous contract close-out audits. The result was that substantial audit effort was devoted to reviews of formula and project grants; university audits, and contract closing -- e.g. 20 percent of audit staff years in FY 1981 were devoted to university audits. Insufficient effort was devoted to the largest Federal responsibilities within the Department: Social Security ($192 billion), Medicare ($55 billion) and Medicaid ($17 billion). Our 1982 - 1983 workplan reflects a redirection of audit effort in response to new OMB initiatives which now require that single audits be conducted, preferably by non-Federal auditors. Furthermore, OMB is requiring significantly greater attention to internal controls within programs and within the Department.

Significant changes will also be reflected in our investigative efforts. Although we will continue to place heavy emphasis on criminal fraud activities we will also place more emphasis on non-criminal sanctions such as civil fraud prosecution, and in administrative and debarment sanctions.

In addition, we will make greater efforts to distill the findings of past reviews in a manner which will make them more relevant to future regulatory, policy and operational decisions within the Department. Greater emphasis will be placed on broad remedy reports which bring together the findings from many audits, reviews or investigations.

Beyond the efficiency to be gained by restructuring the organization we believe more effective use of our staff can be achieved by increasing cooperative ventures with other Inspectors General and with the President's Council on Integrity and Efficiency. Similarly we expect to achieve greater coordination and effectiveness in working with the Department of Justice, the Federal Bureau of Investigations, the Secret Service and other investigative agencies.

The new directions and priorities just described require an altered organizational structure to obtain maximum effectiveness. Thus we have begun taking the steps necessary to implement an OIG reorganization plan.

There are several objectives we hope to achieve by the proposed reorganization. Among the more significant objectives are:

- To provide a greater deterrent by increasing substantially OIG's efforts in the areas of civil fraud and other non-criminal wrongdoing. The Office of Investigations (OI) was in existence prior to enactment of the law which required the establishment of the OIG. At the time, its investigations were limited to criminal wrongdoing, primarily by Department employees. Since OI became a part of the OIG, it has expanded its activities to cover all HHS program areas, but the focus has remained strictly criminal. However, the OIG statute requires the Inspector General to assume responsibility for fraud, abuse, waste, and mismanagement -- suggesting a broad investigatory role, not limited to criminal wrongdoing. Under the reorganization plan, OI will have a Civil Fraud Division. Briefly stated the main functions of this new unit will be to work towards recovering money for the Government through the so-called "civil money penalty legislation" and through the false claims act.

- To improve management by monitoring the Department's performance in regard to taking administrative action in response to misconduct by employees, grantees, contractors, and other program participants. Briefly stated, when the OIG refers cases to appropriate offices for action we will follow-up to assure appropriate sanctions are taken.

- To organize the internal organizational structure of the OIG to conform to the organizational structure within the Department which carry out the principal functions of the Department. Under the reorganization OA, OI, and OSI will each have units devoted specifically to social security, health care financing, and grants and internal systems, which will cover the public health service, human development programs, and procurement activities. In addition OA will now have a Division of ADP Audits with capability to audit computer-based systems. Not only will this approach harmonize better with the organization of the Department and with the principal functional responsibilities of the OIG offices, but it should foster greater cooperation and more joint projects between OIG staff offices -- one of my major management objectives.

In closing, Mr. Chairman, I want to emphasize that we are redirecting OIG efforts toward the programs with the largest dollar outlays and with the most inherently difficult management problems. By early summer we will have our organization realigned to support our new priorities. Thus I believe that OIG can make a more significant contribution to the reduction of fraud and abuse and to increase in efficiency and effectiveness.

Thank you for this opportunity, Mr. Chairman. I will be pleased to answer any questions the Committee may have.

BIOGRAPHICAL SKETCH

Richard P. Kusserow was sworn in as inspector general of the **Department of Health** and Human Services June 10, 1981. He was nominated by President Reagan April 28, 1981, and confirmed by the Senate June 1, 1981.

Prior to becoming inspector general, Kusserow was for 13 years a special agent of the Federal Bureau of Investigation where he specialized in white-collar crime inquiries, much of this time in a supervisory role. He has authored several FBI articles on the investigation of government fraud and corruption.

As inspector general, Kusserow has a two-fold mission: To prevent and detect fraud and abuse in HHS programs and to promote economy and efficiency in the department's operations. His responsibilities include conducting audits and investigations, and other studdies relating to HHS programs.

Kusserow was born in San Jose, Calif., Dec. 9, 1940, and lived there until moving to San Gabriel, Calif., in 1955. He graduated from UCLA with a bachelor's degree in political science in 1963 and received his master's in government from California State University at Los Angeles in 1964. He has done additional postgraduate work at Southern Methodist University School of Law and John Marshall School of Law in Chicago.

During 1965-67, Kusserow served in the U.S. Marine Corps from which he was discharged as a captain. He was an intelligence officer with the Central Intelligence Agency between 1967-1968.

Kusserow joined the FBI in 1969 and worked first in the Pittsburgh division. He was transferred to Chicago in 1970 and worked four years in the white-collar crime squad, specializing in bank fraud investigations as well as fraud against the government, bribery and public corruption cases. Subsequently, he headed a number of governmental fraud investigations, utilizing a variety of innovative techniques. His work helped lead to the development of a permanent governmental anti-fraud program in the Chicago division.

During the last three years in his FBI service, Kusserow was coordinating supervisor of the Chicago Organized Crime Program, overseeing eight squads of agents. Part of that responsibility was the development and management of the Labor Racketeering and Public Corruption Programs. As an authority on governmental fraud investigations, he has participated in training programs throughout the country for the FBI and has been a frequent lecturer at the FBI's National Academy.

Kusserow's wife, Mary, was a social worker with the developmentally disabled in Aurora, Ill. They have a daughter, Carrie, age 4.

June 10, 1981

STATEMENT OF BETTY LOU DOTSON

I appreciate the opportunity to present the fiscal year 1983 budget request for the Office for Civil Rights.

We are requesting $19,163,000 and 524 authorized positions. In addition, $2,350,000 would be transferred from the Social Security Trust Funds.

The fiscal year 1983 request would maintain the Office for Civil Rights at the same operating level as in fiscal year 1982. No program increase is requested. The additional amount of

$2,100,000 requested for fiscal year 1983 represents built-in and cost of living increases, including funds associated with the pay raise and the January 1982 lifting of the executive pay cap.

Compliance Responsibility

The Office for Civil Rights (OCR) is the principal agency responsible for enforcing the nondiscrimination laws in health and human services programs. These laws prohibit discrimination on the basis of race, color, national origin, handicap, and age. There are about 165,000 institutional providers subject to the civil rights laws. OCR's responsibility to ensure that all recipients of Department funds are aware of their civil rights obligations and have taken the necessary steps to comply.

In addition, OCR enforces the community service assurance undertaken by hospitals and other facilities that received funds under Title VI or Title XVI of the Public Health Service Act. In fiscal year 1982, OCR will begin to enforce the nondiscrimination provisions contained in the health care and other block grant programs administered by the Department. These provisions prohibit discrimination on the basis of race, color, national origin, handicap, and age in programs funded by the block grants. They also prohibit discrimination on grounds of sex and religion in health care programs. OCR will implement the provisions by enlisting the support and cooperation of State officials and State agencies in assuring compliance.

To enforce the nondiscrimination statutes, OCR investigates discrimination complaints filed by citizens, conducts compliance reviews, and provides technical assistance through out-reach efforts to encourage providers to comply with the law on a voluntary basis.

Complaint Investigations

Under the implementing regulations OCR must ensure that each citizen complaint of discrimination is addressed in a timely manner. In addition, in recent cases the Federal courts have held that compliance agencies are obligated to take action when information indicating possible noncompliance with the civil rights laws is submitted. Finally, the Department of Justice, which coordinates civil rights enforcement governmentwide, requires each compliance agency such as OCR to promptly resolve complaints alleging race, color, or national origin discrimination in federally assisted programs.

OCR received 1,704 discrimination complaints in fiscal year 1981. Taking account of the historical trend, the number of complaints filed with OCR could rise to a high of 2,000 receipts in fiscal year 1982 and to 2,375 receipts in fiscal year 1983.

In fiscal year 1981 OCR closed 1,540 complaint cases, including cases carried over from the previous fiscal year, leaving a year-end inventory of 600 pending cases. We estimate that OCR will be able to close 1,923 complaint cases in fiscal year 1982 and 2,273 complaint cases in fiscal year 1983.

OCR expects to achieve a higher rate of complaint case closures as a result of productivity increases and a shift of 11 positions from the compliance review function to complaint investigations. In addition, new procedures will be put into effect to resolve more complaints at an early stage to avoid lengthy investigations. OCR will also be exploring new approaches to encourage State involvement in resolving discrimination complaints affecting the block grants. As a first step, OCR must implement a new statutory procedure under which State Governors must be granted up to 60 days to attempt to resolve cases of noncompliance on a voluntary basis.

We propose to allocate 278 positions to complaint investigations in fiscal year 1983, which includes supervisory and clerical staff as well as staff responsible for developing investigative procedures, performing data analyses, and monitoring the workload.

Six staff positions will be allocated to conduct pre-grant reviews of Medicare facilities. These reviews are usually desk audits requiring an examination of beneficiary and service area data. About 1,600 pre-grant reviews will be conducted.

Compliance Reviews and Monitoring

Department of Justice guidelines require compliance agencies such as OCR to establish an effective program of field compliance reviews targeted at a representative number of major grant recipients. Under regulations implementing the nondiscrimination statutes OCR is committed to periodically review the practices of recipients. The purpose of a review is to determine whether program services are being provided in a non-discriminatory manner. If a review reveals compliance problems, the recipient is required to adopt and implement corrective measures.

In fiscal year 1983 OCR will continue to conduct a limited number of compliance reviews. OCR estimates that 121 comprehensive reviews will be conducted in fiscal year 1983. This includes 91 reviews which we anticipate will be carried over from fiscal year 1982, as well as 30 new reviews. OCR expects to complete about 99 compliance reviews in fiscal year 1982 and 96 reviews in fiscal year 1983. OCR proposes to allocate 85 positions to conduct compliance reviews, including supervisory and support staff.

In addition, five positions will be allocated to monitor the implementation of remedial plans in fiscal year 1983. Written corrective plans are often negotiated with recipients in cases where the compliance problems identified during a complaint investigation or review require the development of a comprehensive set of corrective steps to be implemented within an agreed-on time frame. OCR anticipates that 32 remedial plans will be monitored in fiscal year 1983.

Technical Assistance and Voluntary Compliance

Since 1978 OCR has administered a technical assistance program as an integral part of the enforcement effort. Through technical assistance OCR is able to encourage voluntary compliance on a wide scale by making compliance information available to thousands of beneficiaries and health care and social service providers that need guidance. Facilities that receive Department funds have a right to know how to interpret and apply the nondiscrimination requirements in the most effective manner. OCR's technical assistance program is designed to meet this need.

OCR provides technical assistance by: (1) developing and disseminating compliance information to beneficiaries and providers; (2) building the capacity of recipient organizations, organizations of State and local officials, and the Department's program agencies to assist providers in achieving compliance; and (3) providing guidance directly to providers, beneficiaries, and State and local officials. This strategy has produced cost savings for recipients and State and local government agencies, by alerting them to the most effective and least costly means of achieving compliance with the nondiscrimination requirements.

In fiscal years 1982 and 1983, OCR plans to intensify its outreach efforts to prevent serious, widespread compliance problems from arising and to promote voluntary compliance. In part, this effort is aimed at providing State officials with the information and guidance they need to assume a more active role in assuring the compliance of programs funded under the block grants. In addition, we plan to utilize existing compliance information to a greater extent to make sure that a larger universe of recipients are complying with basic civil rights standards.

In fiscal year 1983, OCR will allocate 33 positions to technical assistance, the same number allocated in fiscal year 1982.

Legal Services

OCR's budget request contains 58 positions to staff the Civil Rights Division of the Office of the General Counsel. Division attorneys provide OCR with legal support by: (1) reviewing investigative findings, proposed case settlements, and policy interpretations; (2) conducting enforcement proceedings and referring cases to the Department of Justice when appropriate; (3) interpreting court decisions and providing OCR with legal opinions of court rulings and statutory requirements; (4) assisting the Department of Justice in litigating court cases involving civil rights-related issues; and (5) providing legal guidance in applying the Privacy Act, the Freedom of Information Act, and other statutes and regulations with which OCR must comply.

Program Management

In fiscal year 1983 OCR will allocate 59 positions to provide overall direction and management support.

Management staff determine program objectives and priorities, monitor the compliance effort and evaluate progress, and make final decisions as regards OCR's compliance standards and procedures. In addition, management staff provide the full range of administrative support in such areas as personnel management, budget formulation and execution, financial accounting, management of property and supply systems, and development of ADP programs.

Conclusion

In conclusion, Mr. Chairman, OCR's fiscal year 1983 budget request would provide 524 positions and $19,163,000, together with $2,350,000 to be transferred from the Social Security Trust Funds.

BIOGRAPHICAL SKETCH

Name: Betty Lou Dotson

Position:
Director, Office for Civil Rights
Special Assistant to the Secretary
for Civil Rights
Department of Health and Human Services

Former Positions: Ms. Dotson began her Federal Service in 1956 with the Social Security Administration and served with the Department of Agriculture as: Director of the Civil Rights Staff, Food and Nutrition Service; Assistant to the Director of Equal Opportunity at the Department level; and most recently, Chief of the Adjudications and Complaint Division, Office of Equal Opportunity. She also served as Assistant Director 1975 through 1978 for Equal Opportunity of ACTION.

During 1979 - 1980, Ms. Dotson served at the Joint Center for Political Studies on an Intergovernmental Personal Act assignment.

Ms. Dotson has more than 20 years of experience in the legal and social services areas. Early in her career, she worked in the legal services trust department of the First National Bank of Chicago and for Chicago's Community Legal Counsel. She has been a caseworker for the Cook County Department of Public Welfare.

Education: Ms. Dotson graduated in 1950 from Ohio Wesleyan University with a Bachelor of Arts Degree in Political Science. She earned her J.D. degree from the Lincoln University School of Law in 1954.

Personal: Born in Chicago, Illinois Ms. Dotson currently resides in Washington, D.C. Because of her commitment to the special needs of young women, Ms. Dotson has been active in YWCA volunteer work for many years. She serves as a member of the Board of Directors of the National Capital area YWCA.

STATEMENT OF ROBERT J. RUBIN, M.D.

I am pleased to be here today to present the FY 1983 budget request of the Policy Research appropriation administered by the Office of the Assistant Secretary for Planning and Evaluation. The FY 1983 requested funding level of $14,718,000 will support research in the areas of health, income and employment, and social services policy. This research provides information to the Department and the Administration, the Congress, and other policymakers on current and proposed Departmental programs and the anticipated effects of changes in these programs.

I will now describe the major policy research activities supported by this budget request.

Purpose and Strategy of the Policy Research Program

The Department of Health and Human Services is responsible for planning, operating and evaluating a variety of programs relating to our basic health, social service and welfare needs. The overall purpose of the Department's Policy Research appropriation is to improve the efficiency and cost-effectiveness of these programs and to develop and analyze new approaches to dealing with the problems these programs are meant to alleviate.

In FY 1983 the Policy Research budget will support studies to obtain information on welfare policies, welfare administration techniques, health care policy, and services provided to children, youth, families, the aged and the disabled. This particular research program is unique among Departmental research programs in that it has responsibility for examining broad issues that cut across agency and subject lines. The cross-cutting nature and flexibility of our program allows us to look at important issues such as methods of promoting private sector involvement in the financing and delivery of services, better utilization of volunteers in DHHS programs, and problems of administering welfare programs.

The strategy of this Administration's policy research program is to conduct short-term, focused studies that enable us to respond quickly to changing policy needs and priorities. This represents a shift away from the large-scale multi-year experiments and projects which were conducted by this office in the past. This shift in approach is perhaps best illustrated by ASPE's recent decision to fund in FY 1982 and FY 1983 a series of small, directed retirement policy studies concerned with important issues of retirement decision-making. We believe this shift provides for increased control over research dollars and will result in studies targetted on some of our most current significant social issues.

Applications of Policy Research

Findings from and products of Policy Research projects have made and continue to make important contributions to the development of public policy and to the management of existing programs. Examples of the policy uses of recent activities follow:

- o Research results from the Health Insurance Experiment have played an important role in the development of health competition proposals. Specifically, findings have helped us to estimate the extent to which use of health services would change under alternative proposals that encourage expanding the consumer's choice of health plans. Data derived from this study on issues such as the impact of cost-sharing on health care utilization, and the effect of pre-paid practices on cost and quality of care will continue to be used in the development and refinement of competition proposals. The study results are an important input for policy analysis used by the Congressional Budget Office, the Department and others.

o The requirement of the 1981 Omnibus Budget Reconiliation Act, that states adopt retrospective accounting and monthly reporting practices in the AFDC program, was derived in part from our Welfare Administration Studies. Studies prepared under the Monthly Reporting component of the Welfare Administration Studies continue to support states in this effort.

A report based on the project's demonstration sites provides states with practical lessons in the design and implementation of new policies and procedures. Another report which has been sent to the states contains a more technical summary of the automated management information system which was used to support the administration of monthly reporting policies. In February 1982 Michigan used the ASPE-supported Wayne County demonstration system as a prototype model when it expanded monthly reporting to a statewide system.

o Long-term care research has begun to provide information which may be used to develop policies that support the family in the provision of care to family members, i.e., in-home and community based care for elderly and handicapped relatives. In order to devise finance strategies which coordinate public and private financing mechanisms, we are analyzing existing data to learn such things as the amount and type of care being provided by formal and informal caregivers and to identify existing barriers to family assistance.

FY 1983 Budget Request

The FY 1983 budget request for this appropriation represents a reduction of two million dollars from last year's request. This reduction has been accomplished through a careful review of all policy research activities and reductions in specific large projects in the area of income and employment policy. Projects proposed for FY 1983 focus on issues of concern to this Administration and have been selected on the basis of their potential contribution to current and future policy debates.

ASPE's Health Competition research activities are oriented first and foremost to acquiring information to support health policy development. Much of this activity is devoted to identifying innovative trends taking place in the private sector and their potential for reducing the inflationary spiral in health care. Competition-oriented health policy will rely heavily on the private sector to respond to new cost-inhibiting incentives. A secondary objective of competition research is to create new information in the public domain that may assist the private sector in responding effectively to these incentives.

FY 1983 competition research will consist of four interrelated studies to provide information on alternative competition strategies. These studies will focus on: employee/employer response to multiple choice health insurance options; innovative financing and delivery systems in the private sector; Medicare voucher systems; and changes in payment rates among different purchasers of hospital services.

Our research in innovative financing and delivery systems will continue work initiated in FY 1982. Past research has been devoted primarily to identifying private sector innovations having a demonstrated potential for reducing the rate of inflation in health expenditures. In FY 1983 we will fund research to develop more specific measures of how such innovations as preferred provider plans and health care coalitions bring about restraints in health service consumption and prices.

The establishment of a demonstration and evaluation program for employer-sponsored multiple-choice health insurance plans will be a major priority for FY 1983 competition research. This program will determine which combinations of choices are most efficient, identify risk selection problems, and expand administrative information on how to organize and operate such plans. An important part of this investigation will be to determine employee responses and employer cost experiences associated with rebates offered to employees for selecting low-cost health insurance options.

The Health Insurance Experiment is a large multi-year, multi-site experiment carefully designed to measure the effects of different levels of cost sharing on the demand for medical care; the quality of care given by different types of plans; and the health status of participants after three to five years of participation in these different plans. As I mentioned earlier, this study is contributing directly to the development and analysis of pro-competition strategies and findings are useful in analysis of other health policies. The FY 1983 Health Insurance request will support data processing and analysis activities, since all data collection activities will be completed in FY 1982. Funding for this project will continue to phase down in future years, with anticipated completion in FY 1985.

The Workfare/Welfare Administration Studies consist of the Monthly Reporting Studies and the Welfare-to-Work studies. These studies emphasize improvement in the administrative aspects of welfare, including the demonstration and analysis of new administrative techniques and the study of more effective mechanisms for linking welfare families to the private labor market.

The monthly reporting studies will be completed in FY 1983 thus bringing to a close this multi-year examination of alternative approaches to the design of retrospective accounting and monthly reporting policies. Reports will become available during FY 1982 and FY 1983 with detailed information on income reporting techniques which are most effective for different types of AFDC and Food Stamp clients. These reports will be disseminated during a period when many of the large-caseload states will be implementing their AFDC and Food Stamp monthly reporting system. The various monthly reporting studies will be an important source of information to states in deciding whether to continue monthly reporting under the Administration's New Federalism proposal.

Welfare-to-work studies will be conducted to identify the most effective techniques for promoting unsubsidized employment in the private sector leading to economic independence of welfare recipients.

The new directed Retirement Policy Studies reflect new approaches in policy research to emerging problems in the retirement policy area. During FY 1983 ASPE will continue work on short-term grants for research and analysis relating directly to pressing current policy concerns in the area of retirement policy and economics of transfer programs for the elderly. These studies are intended to be of short duration, to be directly focused on the current issues facing policymakers and their advisers in and out of government, and to develop and present their conclusions in a fashion accessible and meaningful to these policy makers and advisers. One or more of the following high-priority issues will be studied: effects of changes in Old Age Survivors and Disability Insurance (OASDI) on Disability Insurance; transfers within OASDI; private pension response to social security, and the implications of potential increases in the labor supply of the elderly on the labor market. The growth of social security payments from 1.3% of the Gross National Product in 1956 to 5% in 1981 indicates the critical importance of improved information in an area that is and will be the subject of intense scrutiny and debate in coming decades.

ASPE is responsible for overall development of policy alternatives in the area of Long-Term Care. In this role, my staff will provide support to the Department's Long-Term Care Working Group recently created by the Secretary to develop for the FY 1984 budget an initiative which permits an array of long-term care services, recognizes family responsbility, and helps assure quality of care. FY 1983 research will examine methods of financing long-term care that increase consumer choice, cost-consciousness and control over services. My staff will continue to coordinate the Channeling Demonstrations which are testing assessment and case management systems in an effort to determine whether, for the same or less cost, patients can be kept out of nursing homes if they are given necessary services in their own home or in the community.

Conclusion

In this era of constrained budgets, policymakers are faced with difficult decisions regarding the allocation of scarce resources. It has become increasingly important to have information that will allow for informed decisions. The Policy Research appropriation will continue to provide Federal policymakers with timely information which will in turn contribute to future policy decisions.

BIOGRAPHICAL SKETCH

Robert J. Rubin, M.D., was sworn in July 9, 1981, as assistant secretary for planning and evaluation, Department of Health and Human Services. He was nominated by President Reagan April 27, 1981, and confirmed by the Senate June 2, 1981.

Rubin came to his HHS position from Boston, Mass., where he had been associate professor of medicine and assistant dean for government affairs at the Tufts University School of Medicine. He was also serving as chief of the Renal Division in the Lemuel Shattuck Hospital and since 1979 had been consultant to the Senate Labor and Human Resources Committee.

Dr. Rubin, the first M.D. to be appointed assistant secretary for planning and evaluation, is a primary policy adviser to the HHS Secretary, particularly in areas of health care, welfare, Social Security and social services. In these areas he is responsible for the development of the department's legislative program and other major initiatives, and oversees research and evaluation activities.

He was born in Brooklyn, N.Y., Feb. 7, 1946. He received an A.B. degree in 1966 from Williams College in Williamstown, Mass., having been elected to Phi Beta Kappa; and received his M.D. degree from Cornell University Medical College in New York in 1970.

Dr. Rubin interned at the New England Medical Center Hospitals in Boston (1970-71), was junior assistant resident there (1970-72) and a fellow in medicine (Nephrology) in 1974-76.

Dr. Rubin had previously been associated with the old Department of Health, Education, and Welfare and with Secretary Schweiker. As a student he was a U.S. Public Health Service trainee at the Harvard Tissue Immunology Laboratory at the Peter Bent Brigham Hospital, Boston, during the summer of 1968, and was an epidemic intelligence officer in the viral diseases division of the Center for Disease Control from 1972 to 1974. In 1977, as a Robert Wood Johnson Fellow, he worked with then-Senator Schweiker on the development of health policy for the Senate Committee on Labor and Human Resources.

From 1976 to 1978 he was assistant to the dean for government affairs at Tufts University School of Medicine; acting chief of the Renal Division, Lemuel Shattuck Hospital (1978-79); and consultant in Nephrology to the Lakeville Hospital Rehabilitation Center, to the Boston Veterans Medical Center and to the Falkner Hospital.

Dr. Rubin is co-author of numerous articles published by leading medical and scientific journals. He is a member of the American Society of Nephrology, International Society of Nephrology, American College of Physicians, American Federation for Clinical Research and the Massachusetts Medical Society (member Council on Legislation 1980).

He was designated one of the Ten Outstanding Young Men in America in 1978 by the United States Jaycees.

Dr. Rubin is married and has two children.

July 9, 1981

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

REGULATIONS ACTIVITIES

Question: How many regulations were issued by the Department last year?

Answer: The Department published a total of 105 final regulations during 1981 compared with 191 in 1980. It is important to note the distinction between regulations that impose an economic burden upon firms or industries and regulations issued in order to clarify or implement changes in our basic entitlement programs, such as Social Security and Medicare. Most of the regulations issued by HHS in 1981 were in the latter category. For example, in 1981, the Social Security Administration and the Health Care Financing Administration (Medicaid and Medicare) issued 38 and 25 regulations respectively versus 54 and 49 regulations in 1980.

REGULATORY RELIEF

Question: What have your calculations revealed with respect to the overall cost to the private sector and the public of regulations issued during the last year?

Answer: Our regulatory actions within the last year have reduced substantially public and private costs. For example, our regulation implementing the block grants eliminated hundreds of detailed planning, staffing, data collection, and other "red tape" requirements levied on States through prior regulations.

We do not, however, have any detailed calculations of cost savings. At best, identifying and measuring those costs directly attributable to a regulation is a difficult and expensive research task. This is especially true in cases, common in HHS, in which social programs are involved. For example, even in the absence of Federal rules some States will voluntarily create elaborate and expensive planning processes. As another example, in many social programs the regulations do little more than restate statutory requirements, and it is difficult or impossible to distinguish between costs created by statute and those created by the regulations. In the light of these and other difficulties, we do not routinely attempt to measure the costs of regulations. Instead, in developing new or revised regulations we seek to identify the lowest cost alternative consistent with the statute. Therefore, while we are confident that our regulatory actions last year substantially reduced public and private costs, no quantitative savings estimates are available.

Question: Can you delineate some of the accomplishments which have resulted from the work of your task forces on regulatory relief?

Answer: The Secretarial Task Forces on Regulatory Relief initiated the review work on or about January 15, 1982. The basic agenda for most of the Task Forces revolves around those items identified by the President's Task Force on Regulatory Relief for HHS such as: Medicaid regulations, hospital regulations, new drug approval and investigative drug approval, and easing of administrative procedures for the states. Approximately 50 percent of the regulatory review has been completed and Notice of Proposed Rule Making are in the process of being drafted.

ADVISORY COMMITTEES

Question: How many Advisory Committees are currently being funded by the Department? What are they? What is the cost of each to the Department annually?

Answer: In 1982 there are 217 Advisory Committees being funded by the Department at a total estimated annual cost of $32,134,647. The name and annual cost of each committee is as follows:

Advisory Committees	Annual Cost
Advisory Board on Child Abuse and Neglect	$50,000
Advisory Committee to the Director, National Institutes of Health	155,164
Effects of Phenoxy Herbicides and Contaminants	31,935
Aging Review Committee	307,340

Alcohol Biomedical Research Review Committe	98,000
Alcohol Psychosocial Reasearch Review Committee	94,000
Allergy and Immunology Study Section	151,584
Allergy, Immunology and Transplantation Committee	171,891
Anesthetic and Life Support Drugs Advisory Committee	50,000
Animal Resources Review Committee	150,000
Anti-Infective Drugs Advisory Committee	45,000
Arteriosclerosis, Hypertension and Lipid Metabolism Advisory Committee	84,078
Arthritis Advisory Committee	35,000
Arthritis, Metabolism and Digestive Diseases Special Projects Review Committee	264,300
Bacteriology and Mycology Study Section	221,516
Basic Behavioral Processes Research Review Committee	100,000
Basic Psychopharmacology and Neuropsychology Research Review Committee	105,000
Behavioral Medicine Study Section	100,959
Behavioral and Neurosciences Study Section	168,539
Biochemical Endocrinology Study Section	120,355
Biochemistry Study Section	196,201
Biomedical Library Review Committee	113,650
Biomedical Sciences Study Section	254,239
Biometry and Epidemiology Contract Review Committee	169,825
Bio-Organic and Natural Products Chemistry Study Section	89,477
Biophysical Chemistry Study Section (formerly Biophysics and Biophysical Chemistry B Study Section)	121,639
Biopsychology Study Section	155,549
Biotechnology Resources Review Committee	33,000
Bladder and Prostatic Cancer Review Committee	230,867
Blood Diseases and Resources Advisory Committee	125,451
Blood Products Advisory Committee	80,000
Board of Regents of the National Library of Medicine	59,300
Board of Scientific Couselors, Division of Cancer Biology and Diagnosis	45,957
Board of Scientific Counselors, Division of Cancer Cause and Prevention	93,230
Board of Scientific Counselors, Division of Cancer Treatment	100,472
Board of Scientific Counselors, Division of Resources Centers and Community Activities	103,084
Board of Scientific Counselors National Eye Institute	18,300
Board of Scientific Cousenlors, National Heart, Lung and Blood Institute	16,977
Board of Scientific Counselors, National Institute on Aging	15,632
Board of Scientific Counselors, National Institute of Allergy and Infectious Diseases	46,267
Board of Scientific Counselors, National Institute Of Arthritis, Diabetes and Digestive and Kidney Diseases (Formerly Arthritis, Metabolism and Digestive Diseases)	27,700
Board of Scientific Counselors, National Institute of Child Health and Human Development	15,852
Board of Scientific Couselors National Institute of of Dental Research	18,982
Board of Scientific Counselors, National Institute on Drug Abuse	10,000

Board of Scientific Counselors National Institute of Environmental Health Sciences	34,615
Board of Scientific Counselors National Institute Of Mental Health	30,000
Board of Scientific Counselors, National Institute Of Neurological and Communicative Disorders and Stroke	30,155
Board of Scientific Counselors, National Library of Medicine	20,000
Board of Tea Experts	10,000
Breast Cancer Task Force Committee	82,652
Cancer Clinical Investigation Review Committee	253,775
Cancer Control Grant Review Committee	185,063
Cancer Control Intervention Programs Review Committee	31,234
Cancer Research Manpower Review Committee	136,501
Cancer Resources and Repositories Contracts Review Committee	103,170
Cancer Special Program Advisory Committee	320,351
Cardiology Advisory Committee	80,061
Cardiovascular and Pulmonary Study Section	124,956
Cardiovascular and Renal Drugs Advisory Committee	75,000
Cardiovascular and Renal Study Section	152,773
Cell Biology Study Section	178,670
Cellular and Molecular Basis of Disease Review Committee	169,716
Chemical Pathology Study Section	161,625
Circular System Devices Panel	203,000
Clinical Applications and Prevention Advisory Committee	43,038
Clinical Cancer Education Committee	171,331
Clinical Cancer Program Project and Cancer Center Support Review Committee	1,087,946
Clinical Chemistry and Hematology Device Panel	200,000
Clinical Sciences Study Section	143,983
Clinical Trials Committee	96,968
Clinical Trials Review Committee	33,420
Cognition, Emotion and Personality Research Review Committee	115,000
Communicative Disorders Review Committee	130,558
Communicative Sciences Study Section	151,917
Criminal and Violent Behavior Review Committee	125,000
Dermatalogic Drugs Advisory Committee	55,000
Developmental Therapeutics Contracts Review Committee	112,227
Device Good Manufacturing Practice Advisory Committee	20,000
Diagnostic Radiology Study Section	159,472
Drug Abuse Advisory Committee	135,000
Drug Abuse Biomedical Research Review Committee	254,162
Drug Abuse Clinical, Behavioral and Physchosocial Research Review Committee	298,348
Endocrinologic and Metabolic Drugs Advisory Committee	75,000
Endocrinology Study Section	160,356
Environmental Health Sciences Review Committee	279,653
Epidemologic and Services Research Review Committee	292,000
Epidemiology and Desease Control Study Section	231,400
Epilepsy Advisory Committee	25,373
Experimental Cardiovascular Sciences Study Section	99,704
Experimental Immunology Study Section	79,037
Experimental Therapeutics Study Section	112,648
Experimental Virology Study Section	134,852

Federal Council on the Aging	200,000
Fertility and Maternal Health Drugs Advisory Committee	65,000
Gastrointestinal Drugs Advisory Committee	45,000
General Clinical Research Centers Committee	248,000
General Medical Devices Panel	116,000
General Medicine A Study Section	169,240
General Medicine B Study Section	126,884
General Research Support Review Committee	324,000
Genetic Basis of Disease Review Committee	154,608
Genetics Study Section	144,386
Health Care Technology Study Section	140,000
Health Services Research and Developmental Grants Review Committee	260,000
Heart, Lung and Blood Research Review Committee A	610,044
Heart, Lung and Blood Research Review Committee B	380,758
Hematology Study Section	175,993
Human Development and Aging Study Section (formerly Human Development Study Section)	196,437
Human Embryology and Development Study Section	129,388
Immunization Practices Advisory Committee	62,000
Immunobiology Study Section	124,240
Immunobiology Sciences Study Section	138,674
Immunology and Microbiology Devices Panel	180,000
Interagency Committee on Federal Activities for Alcohol Abuse and Alcoholism	34,000
Large Bowel and Pancreatic Cancer Review Committee	213,885
Life Course Review Committee	200,000
Mammalian Genetics Study Section	147,673
Maternal and Child Health Research Committee	207,644
Maternal and Child Health Research Grants Review Committee	30,267
Medical Radiation Advisory Committee	75,000
Medical Chemistry Study Section (formerly Medicinal Chemistry A Study Section)	142,797
Mental Health Research Education Review Committee	400,000
Mental Health Small Grant Review Committee	222,000
Mental Retardation Research Committee	206,301
Metabolism Study Section	151,302
Metallobiochemistry Study Section	120,448
Microbial Physiology Study Section	167,993
Microbiology and Infectious Deseases Advisory Committee	125,711
Mine Health Research Advisory Committee	100,000
Minority Access to Research Careers (MARC) Review Committee	163,698
Molecular Biology Study Section	117,963
Molecular and Cellular Biophysics Study Section (formerly Biophysics and Biophysical Chemistry Section A Study Section)	122,761
Molecular Cytology Study Section	133,823
National Advisory Allergy and Infectious Diseases Council	246,782
National Advisory Child Health and Human Development Council	305,916
National Advisory Council on Aging	91,556
National Advisory Council on Alcohol Abuse and Alcoholism	40,000
National Advisory Council on Drug Abuse	65,000
National Advisory on Health Professions Education	121,560
National Advisory Council on Migrant Health	44,850

National Advisory Council on the National Health Service Corps	78,000
National Advisory Council on Nurse Training	76,000
National Advisory Dental Research Council	71,976
National Advisory Environmental Health Sciences Council	103,933
National Advisory Eye Council	141,500
National Advisory General Medical Sciences Council	351,800
National Advisory Mental Health Council	93,000
National Advisory Neurological and Communicative Disorders and Stroke Council	303,412
National Advisory Research Resources Council	141,000
National Arthritis Advisory Board	300,000
National Arthritis, Diabetes and Digestive and Kidney Deseases Advisory Council (formerly Arthritis, Metabolism and Digestive Diseases Advisory Council)	372,500
National Cancer Advisory Board	503,868
National Committee on Vital and Health Statistics	94,500
National Council on Health Planning and Development	95,000
National Diabetes Advisory Board	300,000
National Digestive Diseases Advisory Board	300,000
National Heart, Lung and Blood Advisory Council	542,290
National Institute of Dental Research Programs Advisory Committee	38,513
National Institute of Dental Research Special Grants Review Committee	132,150
National Professional Standards Review Council	75,000
National Toxicolgy Program Board on Scientific Counselors	97,000
Neurological Disorders Program-Project Review A Committee	266,766
Neurological Disorders Program-Project Review B Committee	259,507
Neurological Sciences Study Section	132,435
Neurology A Study Section	131,687
Neurology B Study Section	234,360
Nutrition Study Section	126,878
Obstetrics-Gynecology and Radiologic Devices Panel	165,000
Oncologic Drugs Advisory Committee	55,000
Ophthalmic Drugs Advisory Committee	55,000
Ophthalmic, Ear, Nose, Throat and Dental Devices Panel	215,000
Oral Biology and Medicine Study Section	231,387
Orthopedics and Musculoskeletal Study Section (formerly Applied Physiology and Orthopedics Study Section)	139,227
Pathobiological Chemistry Study Section	124,111
Pathology A Study Section	134,574
Pathology B Study Section	148,067
Peripheral and Central Nervous System Drugs Advisory Committee	45,000
Pharmacological Sciences Review Committee	191,506
Pharmacology Study Section	130,987
Physical Biochemistry Study Section	91,612
Physiological Chemistry Study Section	141,704
Physiology Study Section	132,403
Population Research Committee	198,647
President's Cancer Panel	28,789
President's Committee on Mental Retardation	836,719

President's Council on Physical Fitness and Sports..	75,000
Psychopharmacologic Drugs Advisory Committee........	80,000
Psychopathology and Clinical Biology Research Review Committee..	227,000
Pulmonary-Allergy Drugs Advisory Committee..........	50,000
Pulmonary Diseases Advisory Committee...............	74,317
Radiation Study Section.............................	143,592
Radiopharmaceutical Drugs Advisory Committee........	50,000
Rape Prevention and Control Advisory Committee......	40,000
Recombinant DNA (Deoxyribonucleic) Advisory Committee..	152,455
Reproductivity Biology Study Section................	155,407
Research Manpower Review Committee..................	41,807
Research Scientist Development Review Committee.....	168,000
Respiratory and Nervous System Devices Panel........	120,000
Safety and Occupational Health Study Section........	265,000
Science Advisory Board to the National Center for Toxicology Research..............................	60,000
Scientific Programs Advisory Committee, NINCDS (formerly Neurological and Communicative Disorders and Stroke Science Information Program Advisory Committee).......................................	48,243
Secretary's Advisory Committee on the Rights and Responsibilities of Women..........................	100,000
Sickle Cell Disease Advisory Committee..............	66,081
Social Sciences and Population Study Section........	143,810
Surgery, Anesthesiology and Trauma Study Section....	143,203
Surgery and Bioengineering Study Section............	131,631
Surgical and Rehabilitation Devices Panel...........	210,000
Technical Electronic Product Radiation Safety Standards Committee..............................	85,000
Toxicology Study Section............................	184,849
Treatment Development and Assessment Research Review	327,000
Tropical Medicine and Parasitology Study Section....	130,673
Vaccines and Related Biological Products Advisory Committee..	90,000
Virology Study Section..............................	124,365
Vision Research Program Committee...................	161,925
Visual Sciences A Study Section.....................	223,511
Visual Sciences B Study Section.....................	130,176
1981 White House Conference on the Aging Technical Committee..	5,000
Total..................	32,134,647

UNIVERSITY OF CHICAGO STUDY

Question: A recently published report by the University of Chicago's Center for the Study of Social Policy, based on evidence from 48 states, apparently shows that under the Reagan program, poorer people are likely to lose money by working. What is your comment on the study's finding?

Answer: We find the University of Chicago study defective in several respects:

o The study assumes that able-bodied individuals will have the option of going on welfare without working.

This assumption is inconsistent with the philosophy of this Administration. The AFDC program should not be considered an alternative to work.

Strengthening work requirements is one of the key components of our 1983 budget. We should require mandatory job search and community work experience programs for all able-bodied recipients. We are also proposing to sanction recipients who voluntarily quit a job or reduce their work hours. The University of Chicago study downplays these provisions.

- The claim that welfare recipients in various States will be significantly better off by not working is essentially untrue. The study greatly overstates estimated work expenses for earners by using outmoded data. Once this mistake is corrected for, it turns out that AFDC households will be receiving about the same amount of disposable income, whether working or not.
- The study presents no valid empirical evidence to support its conclusion that these welfare program changes will result in people quitting their jobs and going back on welfare (or reducing the number of hours they work). The only empirical evidence in the University of Chicago study comes from another academic study. The authors of this other study obtained completely inconsistent results with regard to the total impact of these changes on both current and potential welfare recipients.

We believe that our proposals will actually enhance the incentives for welfare recipients to seek employment.

BLOCK GRANTS

Question: How much money was saved in day-to-day management last year over the year before due to the institution of block grants?

Answer: A number of problems exist in estimating Federal administrative savings that can be directly attributed to block grants. These include accounting for the influence of factors not related to block grants, the effects of continuing categorical programs for some States during the transitional year, etc. Nevertheless, rough estimates have been made of administrative savings in FY 1982 as compared to FY 1981, and are presented below. These estimates are drawn primarily from the Department's FY 1983 budget justification. (The extensive organizational changes associated with the creation of the Community Services Block Grant have precluded any meaningful estimates being made for this program. Estimated total savings are therefore considerably understated.)

Estimated Federal Administrative Savings in FY 1982 Associated with Conversion to Block Grants

Block Grant	Estimated Savings ($ in millions)
1. Primary Care; Maternal and Child Health	$ 5.2

2.	Preventive Health; Alcohol, Drug Abuse, and Mental Health	22.2
3.	Low-Income Home Energy Assistance	0.5
4.	Social Services	1.5
5.	Community Services	Not Available
	Total	$29.4

Question: To what extent did block grants result in less money being lost due to mismanagement, inefficiency and systems problems during the last year?

Answer: Since Fiscal Year 1982 is a transitional year in the implementation of the block grants, little information is now available on administrative savings resulting from the block grants. Many states are planning to make changes in administrative structures and to streamline procedures in block grant program areas, but have not yet implemented these changes. A few States have implemented changes, but even in those instances it is too early to determine their precise impact and to document resulting improvements in management or efficiency. By Fiscal Year 1983, which for most States begins in July 1982, States will be in a better position to determine what administrative functions can be eliminated or reduced. Consequently, the Department expects to have some information in the Fall of 1982 on administrative savings.

CIVIL RIGHTS AND BLOCK GRANTS

Question: How has the role of the Office for Civil Rights changed with the enactment of block grants?

Answer: The Office for Civil Rights is in charge of enforcing the nondiscrimination provisions contained in the block grant statutes. Under these provisions the Office must notify State Governors whenever discrimination is found to exist in the block grant programs. The Governors, in turn, have up to sixty days to attempt to secure voluntary compliance. If a settlement cannot be reached, the case is returned to the Office for Civil Rights for enforcement. The mechanism will necessitate coordination and a working relationship with State officials in regard to civil rights cases affecting block grant programs. The Office for Civil Rights will be embarking on an effort to involve the States in assuring compliance with the nondiscrimination provisions.

STATE CIVIL RIGHTS UNITS

Question: What is the working relationship between Federal and State Offices for Civil Rights?

Answer: There is no statutory or regulatory requirement under which the Office for Civil Rights must defer to State agencies in processing cases of discrimination. Hence, up to the present time we have worked with State human rights agencies only on an as-needed basis in handling individual cases or issues. For example, we will make compliance information available to State or local human rights agencies and our regional offices will coordinate investigative work to avoid duplication of effort. One of our goals is to strengthen and expand these relationships in the future, particularly with State and local agencies that have comparable jurisdiction and enforcement authority. This can be advantageous to both parties. State program agencies, as opposed to the human rights agencies, have carried out a range of civil rights compliance activity under Title VI of the Civil Rights Act.

AFFIRMATIVE ACTION

Question: In what ways does the Office for Civil Rights become involved with affirmative action plans?

Answer: None of the civil rights statutes we enforce specifically requires affirmative action in employment. In addition, the applicability of Title VI of the Civil Rights Act to employment is limited, and the Age Discrimination Act does not cover employment. In those cases where the Office for Civil Rights investigates and makes findings of employment discrimination, the provider is required to correct the discrimination. If the case involves a pattern or practice of discrimination, a corrective plan may be necessary in which the provider sets forth the steps that will be taken to remedy the violations.

CIVIL RIGHTS FINDINGS

Question: Please summarize some of the findings of your field compliance reviews carried out with regard to practices of major grant recipients during the last year.

Answer: Under Title VI of the Civil Rights Act, the Office for Civil Rights reviewed a large number of State program agencies and, in many of these cases, the agencies were found to be in violation of the Title VI regulation because they were not monitoring the compliance status of their vendors, informing staff and beneficiaries of compliance responsibilities, and maintaining complete and accurate records. In several cases hospitals and other service agencies were found to be violating Title VI because they had failed to take steps to ensure that limited English-speaking clients, applicants, or other beneficiaries were not excluded from program services. The Office for Civil Rights has reviewed several hospitals and other facilities to ensure that minorities have equal access to program services. In some instances, the Office found that hospitals had failed to remedy past practices of segregation or other forms of past discrimination. In one case, it was found that a State health care commission violated Title VI in the process of appointing board members and in excluding members of the public from meetings.

The Office for Civil Rights also enforces the "community service assurance" of the Hill-Burton Act. Under this provision, the Office found that many hospitals were not complying with the "community service assurance" as specified in the regulation. For example, violations were cited in these areas: restricting the number of Medicaid patients; refusal to accept Medicaid reimbursement for emergency treatment; maintaining discriminatory preadmission deposit policies; and staffing the facility only with staff physicians who do not accept Medicaid payment. In one case, a review disclosed that an admissions procedure followed by a hospital had the effect of limiting admissions of indigent obstetrical patients on grounds unrelated to the need for the service.

Under Section 504 of the Rehabilitation Act, several cases involved the failure of particular facilities to provide reasonable accommodation to handicapped employees and applicants for employment. In other instances, facilities were limiting employment opportunities because of preemployment inquiries on application forms that violate Section 504. In numerous cases facilities had not evaluated the compliance status of their programs as required. In addition, many facilities were cited for failure to make their programs or services accessible to handicapped persons, including the failure to provide appropriate auxiliary aids to persons with impaired sensory skills.

CIVIL RIGHTS SAFEGUARDS

Question: What controls exist in the administration of block grants to protect against civil rights and financial abuses?

Answer: The block grant legislation contains explicit civil rights protections. Except for the social services block grant, each of the HHS block grant programs passed by Congress prohibits discrimnation on the basis of race, color, national origin, handicap, sex, and age. Some also bar discrimination on grounds of religion. These nondiscrimination provisions will be enforced by the Office for Civil Rights with the support and cooperation of State officials. Programs funded under the social services block grant are subject to Title VI of the Civil Rights Act and other cross-cutting civil rights requirements. In addition, there are planning, reporting, and auditing procedures required by the block grant statutes.

PROMOTING PRIVATE SECTOR INVOLVEMENT IN SERVICE DELIVERY

Question: What have your studies revealed with respect to methods of promoting private sector involvement in the financing and delivery of services?

Answer: Policy Research funds have not been used to date to study methods of promoting private sector involvement in financing and delivery of services. However, the Department has several projects in planning stages, proposed for funding in FY 1982 and FY 1983, which directly bear on this subject. Areas for investigation include emerging private sector initiatives, such as business sponsorship of human services for employees and the use of volunteers as an added resource to service providers. Results from these studies will be available in one or two years.

POSITION REDUCTIONS

Question: Of those 284 positions which were eliminated during the last year, how many were:

--Handicapped
--Women
--Blacks
--Hispanics
--Native Americans
--Elderly?

Of these groups, please identify the percentages of individuals in clerical, technical and administrative positions.

Answer: The 284 positions that were eliminated were all vacant. These vacancies were achieved through attrition.

EMPLOYEE PLACEMENT

Question: How successful has the Department been with regard to a placement program for those people losing their jobs?

Answer: The Department's efforts to place people has been quite successful. We have placed over 900 employees from HHS organizations facing reductions-in-force into other parts of the Department. Another 225 employees have been placed in other Federal agencies, and approximately 50 employees have been placed with private companies. We have succeeded in dramatically reducing the number of employees who had to be involuntarily separated. For example, the Public Health Service originally anticipated that it was going to have to separate over 500 employees in the Washington, D.C. area. As the result of our placement assistance programs, this number was reduced to less than 100. The office of Human Development Services originally projected over 250 employees throughout the country. We were able to reduce this number to 43. Our placement efforts have included outplacement activities (such as job clubs, job fairs, seminars and training sessions for affected employees and letters and personal contacts with other potential employers); a freeze on hiring, which opened up numerous placement opportunities within the Department; and early out retirement authorizations, in which the vacancies left by retiring employees were used to place affected employees. We are pleased to report that Congressman Michael Barnes, Chairman of the Federal Government Service Task Force, recently singled out our Department as a model for placement efforts within the Federal sector.

FLEXITIME

Question: Do you find productivity is decreasing because all persons are not available during the same hours?

Answer: An internal study indicated no real evidence of decreases in productivity, however, there were times when nonsupervisory staff arrived at work earlier than the supervisor and during this period the staff was not always productive.

Question: What have been the advantages and disadvantages of employee flexitime?

Answer: Our internal study revealed that under flexitime there was a decrease in absenteeism, tardiness was eliminated, accessibility with public and field operations in different time zones was improved and employee morale was positive. The disavantages found were a decrease in supervisory control, abuses to the time accounting system and difficulty in maintaining office coverage during the morning and evening flexible bands.

DEPARTMENTAL ATTORNEY STAFF AND BUDGET

Question: How many attorneys are on staff at the Department, and what portion of the budget is reserved for this purpose?

Answer: There are 814 attorneys on the staff of the Department. The Office of the General Counsel employs 343 attorneys, the Grant Appeals Board employs 16 attorneys, Saint Elizabeth's Hospital employs 5 attorneys, and the Social Security Administration Office of Hearings and Appeals employs 450 attorneys.

The approximate annual salary cost for all 814 attorneys is $25,497,000.

TRAVEL

Question: How many annual trips per capita were made last year by Department employees?

Answer: We estimate that we had 261,730 trips, excluding local travel, for fiscal year 1981. This would equate to 1.94 trips per person based on staff on board at the end of the year. This estimate is based on a statistical sample taken in 1981 for 1980 travel.

Question: To what extent has the institution of block grants reduced the necessity for Department employees to travel?

Answer: Because only a few months have elapsed since the first block grants were issued, the full impact is not yet known. However, we do know that a number of administrative functions will be reduced. Travel requirements will be reduced in such areas as program oversight, program reviews, and determination of allowability of items of reimbursable costs. The Department will, of course, continue to incur travel costs in responding to requests for technical assistance, particularly in implementing block grants.

At this early stage we are finding a mixed reaction. For example, the Social Security Administration is estimating an increase in travel in order to service and audit the Low Income Home Energy Assistance Program grants, largely because Indian tribes now qualify for the program. This added 127 grants to the existing 54 grants. On the other hand, the Office of Community Service spent about $1.9 million last year to monitor grants. Due to block grants, they expect to reduce this travel by approximately 50 percent.

In summary, we are satisfied that Departmental travel will be reduced as a result of block grants - the extent of the net decrease cannot be quantified definitely at this time.

INCREASE REQUESTED FOR FY 1983

Question: For what purpose is the $3.3 million increase requested for the Office of the Inspector General above the FY 1982 level?

Answer: The $3.3 million represents a net change in the OIG's budget authority between FY 1982 and FY 1983. The change is composed of $1.6 million in increased costs for the October 1981 pay raise and the lifting of the executive pay cap in January of 1982; built-in or non-controllable costs of $2.8 million for such things as rate increases for telephone, rents, and postage; and $1.7 million to restore the non-Federal contract audit program to the approved level. These increases are partially offset by a $2.8 million decrease in the Federal cost of the State Medicaid Fraud Control Units because of the Federal matching rate reverting from 90 percent to 75 percent.

FRAUD, WASTE, AND ABUSE

Question: In your statement, you indicated that the Office of the Inspector General will now concentrate its efforts on identifying the processes in the Department's programs which give rise to fraud, waste and abuse. Please explain how this differs from previous policy and what, if any, findings have resulted thus far from this change in emphasis.

Answer: Over time, shifts in policy, program requirements economic conditions and staff size have required us to develop new plans to meet new challenges. Calendar year 1981 represented our first concentrated effort to put together a comprehensive OIG long range work plan. We were confident that our organization and our priorities closely matched the needs of 1977-1980. We were not certain that the needs of 1981 and beyond were as well served.

As a result of our work planning, process, we believe that we must change some of our organization and work priorities to meet the demands of the future.

Challenge of Computers

Today more of the Department's programs are using computers to perform significant functions. The Social Security Administration, (SSA) for example, has one of the world's largest computer complexes. Increasingly, we are finding that these computer systems are causing many problems. As a result, the OIG staff must increase its computer skills and we must be more involved in the design, control and security of all aspects of computer systems.

Challenge of Fastest Growing Programs

Because of Congressional enactments, changes in Office of Management and Budget (OMB) policy and overall economic conditions, more and more concern is being expressed over the problems of Social Security Trust Fund Programs, Medicare and Medicaid. These are the fastest growing programs and the programs which experience has shown to have significant problems of fraud, abuse and waste.

As a result, we are shifting more of our resources into reviewing these major programs. Furthermore, a review of past investigations indictated that many Departmental employees or recipients of Departmental funds who were involved in crimes or serious violations of contracts or regulations, received relatively light punishment for their infractions. We also felt that substantial money recoveries were often lost. As a result, we started a review of methods which could be employed to impose administrative sanctions against wrongdoers and methods which could be used to impose civil restitution and penalties where appropriate.

By using the best analytical capabilities we have developed the Management Implications Report (MIR) system. MIR's are reports, written by investigators that describes the program being investigated, the integrity controls in place which affected the matter under investigation, and how the controls worked or did not work. The management reviews and audits of the Social Security Number Issuance System are examples of one of the by-products of the MIR system. The enormous success of the projects developed thus far has resulted in the decision to increase the resources assigned to such projects. It is expected that these new projects will be very successful in detecting and prosecuting fraud and criminal misconduct in DHHS programs, and will serve as a significant deterrent to future fraud.

BLOCK GRANTS

Question: How has the role of the Office of the Inspector General changed with the enactment of block grants?

Answer: In the process of moving to block grants, you have a devolution of responsibility upon state and local entities. Built into that is the notion that having the flexibility to make decisions on the utilization of block grants goes the responsibility for auditing those funds. So we forsee our effort changing somewhat to overseeing and reviewing the audit processes by the states and local entities, and also in the private sector when they are involved in the process. Bottom line, the states will audit the programs. We will oversee and review the audits and provide technical assistance to the states on how to conduct such audits if such guidance is needed. We are working closely with OMB and the IG's of other department's with block grants to develop a consistent audit program.

OIG ADVANCE APPROPRIATION REQUEST

Question: We understand that you are requesting an advance appropriation for the Inspector General's office, rather than the annual appropriation which includes "borrowing." What specifically do you have in mind?

Answer: Two new sections dealing with State Medicaid Fraud Control Units have been included in the FY 1983 appropriation language to replace the section concerning borrowing authority. One section provides that the costs for the last three months of FY 1983 may be financed, if necessary, from funds of the next fiscal year. This would safeguard recipient States under the State Medicaid Fraud Control Unit grants program. If the appropriation estimates prove to be too low, grants to the States would continue without interruption. The FY 1983 appropriation stipulates that the funds financed from the next year for higher than budgeted costs in FY 1983 may not exceed $5,000,000.

The second new section of the OIG appropriation language was added to provide for an advance appropriation for making grant awards for the first quarter of FY 1984. This provision will eliminate the need for "borrowing" funds from FY 1984 for making grant awards in FY 1983 for the first quarter of FY 1984. As a result of this new language, beginning with FY 1984, the budget authority and appropriation amounts for the budget year will be the same.

AUDIT RESOLUTION

Question: What is the current number and percentage of unresolved audits in the Office of the Inspector General?

Answer: As of February 28, 1982, the current number of unresolved audit reports containing questioned costs was 457. Of this number, 64 or 14% will become six months old in March. The Department is confident that all 64 will be resolved by the end of March.

Question: What is the estimated monetary amount involved in these unresolved audits?

Answer: The estimated monetary amount of questioned costs involved in these unresolved audits is $103.2 million.

Question: What specific action is being taken to conclude these unresolved audits as quickly as possible?

Answer: We have a policy which requires that all audit reports be resolved within six months of their issuance. We monitor through monthly reporting the progress of the Operating Divisions in accomplishing this objective.

NURSE MIDWIFERY

Question: The G.A.O.'s report, Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome, enumerated a number of barriers to increased utilization of certified nurse-midwives: "a limited supply, few training programs, physician resistance, non-availability of obstetricians with whom to work, reluctance of some nurse-midwives midwives to practice in rural or other undesirable areas, and restrictive state licensing or third party reimbursement practices". Subsequently, the Department formed a "working group" to address these issues and apparently, this group met at least three times, the last being in December, 1980. The Committee would appreciate receiving a report on the status of this "working group", and in particular, initiatives developed by the Department to insure that certified nurse-midwife services will be made more available to our citizenry. The committee would especially appreciate learning of the Department's plans for funding nurse-midwifery training programs in FY '83.

Answer: The "working group" convened by the Department has held a series of meetings to develop recommendations based on the findings of the G.A.O. report. Preliminary recommendations have been developed and progress has been made in the areas of new legislation and regulations. Since publication of the G.A.O. Report, the Congress has passed legislation to expand Federal reimbursements for nurse midwives and the Health Care Financing Administration (HCFA) has broadened its regulations for reimbursements to nurse midwives under Medicare and Medicaid. The most recent meeting of the "working group" was in March 1981. The Department expects to reconvene the "working group" to examine further the utilization of nurse midwives under new health programs such as the block grants to States.

In FY 1983 the Department is requesting a total of $2.4 million to train approximately 105 nurse-midwives through the Advanced Nurse Training and Nurse Practitioner program in the Health Resources Administration.

SUBCOMMITTEE RECESS

Senator RUDMAN. We stand in recess.

Thank you.

[Whereupon, at 3:15 p.m., Friday, March 5, the subcommittee was recessed, to reconvene at 9:30 a.m., Monday, March 8.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1983

WEDNESDAY, APRIL 14, 1982

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 10:10 a.m., in room 1114, Everett McKinley Dirksen Senate Office Building, Hon. Harrison Schmitt (chairman) presiding.

Present: Senators Schmitt, Andrews, Abdnor, Specter, Burdick, and Inouye.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF RICHARD S. SCHWEIKER, SECRETARY

ACCOMPANIED BY:
DAVID SWOAP, UNDER SECRETARY
THOMAS DONNELLY, ASSISTANT SECRETARY FOR LEGISLATION
DALE SOPPER, ASSISTANT SECRETARY FOR MANAGEMENT AND BUDGET

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. The hearing will come to order. I wish you all good morning. Welcome to the resumption of our fiscal 1983 hearings on the budget requests for the Departments of Labor, Health and Human Services, Education and Related Agencies.

Today we are beginning our series of hearings with the Department Secretaries, continuing what may or may not become a tradition of trying to make sure that the committee fully understands the budget requests before we have a chance to work directly with the Secretaries of the various Departments.

I am very pleased today to welcome as our witness a former colleague who, had he not elected to retire from the Senate, would be sitting where I am sitting today——

Secretary SCHWEIKER. I am not sure who is better off. [Laughter.]

Senator SCHMITT [continuing]. But who is now Secretary of Health and Human Services. Mr. Secretary, it is great to have you here, and I am sure you are going to put into a fine, coherent presentation the needs of your Department and how those needs, as well as the needs of the people you serve, are going to be met by the budget requests this year.

We already have heard from the line agencies at HHS, so it is now time to go back and review the areas where questions remain and to have the Secretary give us the broader picture of his Department's operations and plans and perspectives for the future.

The Department of Health and Human Services will spend almost $269 billion in 1983, of which $65.5 billion is subject to annual appropriation and $203.5 billion is provided through trust funds. The Federal Government's commitment to provide quality health and social services is met through programs administered by the Public Health Service, the Health Care Financing Administration, the Social Security Administration, and the Office of Human Development Services and numerous smaller agencies within the Department.

I should add that we still are faced with this extraordinarily difficult situation where the continuing growth of entitlement programs is squeezing discretionary programs—which are equally important, if not in some cases more important—tighter and tighter. That issue must be addressed as soon as is humanly possible, or we are going to find, Mr. Secretary, that you and I don't have much to talk about anymore. It would be merely a question of appropriating money to fund the entitlement programs without any discretion left in serving the health, education, and other important discretionary needs and activities of your agency.

You are most welcome here, Mr. Secretary. Please introduce whatever associates you wish to introduce. As usual, I notice you are alone at the podium, but if you need assistance, please introduce the people assisting. Mr. Secretary.

Excuse me. Maybe Senator Andrews has something to say.

Senator ANDREWS. I want to wait until the Secretary has remarks in the record and we can do it on a question basis. As the chairman has stated quite well, the Secretary was a colleague of mine in the House for a good long time. We were among those, shall we say, moderate liberal Republicans.

But these programs are some of the most important investments in the future of our Nation, and I have just been darn proud of the job you have been doing, under, shall we say, somewhat adverse circumstances over there, in maintaining the funding level and the operation levels for programs that are so important. Actually, you're making do with less dollars but getting the results out.

You do a fantastic job, Dick. We appreciate that. We only wish we could give you a little bit more substance, because a lot of those areas that are being cut back are extremely important. They are not spending programs. They are investment programs in the future of this country, and some of the research that they do at NIH and some of the basic research in other areas are investments in the future of mankind.

I think this is the kind of program that we have to maintain and move ahead with them. The chairman of the subcommittee shares that feeling. That is why I am privileged to work with him.

Senator SCHMITT. Over here we call it the commonsense Republicans rather than moderate to liberal Republicans. [Laughter.]

Senator ANDREWS. Well, over in the House we called ourselves moderate to liberal Republicans. A couple of friends of ours, one of whom later became a Senator and one of whom later became a Governor, decided that we were going to tell the Democrats what to do. So we got together—remember, Dick—the constructive Republican alternative proposals. Then they got into the acronym, and we backed away from it.

OK, have fun.

Senator SCHMITT. Mr. Secretary.

Secretary SCHWEIKER. Thank you, Mr. Chairman, Senator Andrews. I am delighted to be back in my old environment again and appreciate the statements of both my former colleagues.

Knowing how dry and boring opening statements can be, I am going to ask to put my opening statement in the record, but I would like to show you some charts, which make some salient points that are very germane to your job and my job as well. I will start out with just a very quick overview of what I feel some of our accomplishments are in the first year plus 3 months of our term and my term as Secretary.

NEW NATIONAL HEALTH AGENDA

I have set up a new national health agenda, putting wellness at the top of that agenda. We have set up a basic task force at NIH to focus on preventive health care, so that our health dollars have some focus and target in terms of cost effectiveness for preventive health care.

We have set up a task force on medical schools to encourage medical schools to put more emphasis on health prevention and health promotion into their curriculum instead of just disease treatment. They are very cooperative and supportive, and we can see some changes occurring there. We are working with the advertising council to get one of their free slots for a national advertising campaign for wellness and health promotion, which looks quite encouraging.

You have no doubt seen the cover of one leading news magazine which espouses our low-sodium policy at FDA, which is part of our wellness effort.

FOOD LABELING

Senator ANDREWS. Could I interrupt right here and put it right up front? It is important. I have been involved in labeling for 15 years, and whether we have been working under a Republican administration or a Democratic administration—I think my interest goes back at least four or five administrations—we can't seem to encourage Food and Drug, Health, Education, and Welfare—which is Health and Human Services—or any other groups to get their act together. We need more than just sodium labeling. We need clearcut, precise labeling on all the foods that are processed in this country.

Are you intending to include more as part of your wellness effort, or limit it just to sodium labeling, which I share with you is extremely important. But I think we have got to have more than sodium labeling.

Secretary SCHWEIKER. Under our program now, of course, there are many other items that do have labels other than sodium, including fat, cholesterol, carbohydrate, and protein content.

Senator ANDREWS. Except you have got cooking oils and margarines and what not being advertised on television as containing no cholesterol. Well, they don't. Very few of them contain cholesterol. The important thing in the various margarines is the percentage of saturated and unsaturated fats. But if they are allowed to go ahead, and advertise that they contain no cholesterol, everybody is going to think that brand X is as good as brand Y when brand X is consistently different than brand Y.

That is why we need polyunsaturates and a lot of other things labeled clearly and effectively. So, I would hope you wouldn't limit it to sodium labeling.

Secretary SCHWEIKER. Well, we aren't, and I appreciate your sentiment in that respect. I would agree with your point on saturated and unsaturated fats. That is a very high element, particularly for heart attack victims.

We are also working with the private sector to encourage their wellness programs. Some corporations pay people so many cents a mile to jog, to walk, and to do other exercises under their auspices.

HEALTH CARE COSTS

We have before the President three proposals for competition to hold down our health care cost problems. I will be talking more about those a little bit later on.

We did get a slight increase in the NIH budget. Unlike some of my other discretionary programs that got cut 20 to 25 percent, NIH did not. We have got some 52 Nobel Prize winners at NIH whom we are very proud of. We have got to keep that facility on target and keep our funds reasonably well supplied.

In deregulation, we did have about 25 programs that were consolidated into 7 different block grants.

We are trying to phase out our Federal health planning role and make some progress in the drug lag. This year we set a record: 27 new drugs were approved. That is the highest since the 1962 law was passed.

WASTE, FRAUD, AND ABUSE

We hope in the year just ending to save about $2 billion in waste, fraud, and abuse. We initiated some things that, although they seem obvious, nobody had done before, such as to put a computer check on the deceased list and stopped payments to dead beneficiaries receiving black lung benefits and social security benefits. We just gave a $5,000 prize to the employee who came up with this idea.

Interestingly enough, it was suppressed for 2 years. We received the idea and helped save almost $60 million by running a computer check on deceased people on medical lists against recipients on our other lists of payouts.

We transferred some seven public hospitals to private usage. Baltimore, Seattle, and Staten Island communities have taken over those hospitals. So, we have made some real progress—not just dumping them on the area, but basically getting them into the private sector.

By targeting welfare benefits, we expect to save about $11 billion over the next 5 years. We cut our employment by about 7 percent, or 11,000. About half of that was Public Health Service hospitals. We cut our travel expenses by 20 percent.

REACTION TO BLOCK GRANTS

Senator SCHMITT. Dick, in your prepared remarks or for the record, can you prepare us a summary of how the various States have reacted to the block-grant proposals and what the experience to date is?

Secretary SCHWEIKER. Yes; we have gotten a very favorable response. Let me say quickly that almost all the States have participated, a very positive response—95 percent of them have elected to participate in the blocks. We will be glad to give you that.

Senator ANDREWS. When do you think it is actually going to happen, Dick?

Secretary SCHWEIKER. Well, it has happened. In other words, most of the States have already opted to run most of the block programs themselves.

Senator ANDREWS. So they are going out in block grants?

Secretary SCHWEIKER. We are sending checks out now, and have been, on some of them. Let me say, Mark, that there are one or two that are in different phases. Some are operative now and some are not, but all those that are operating now have been widely accepted and are going out as block grants now. There are some that are not yet. But I will be glad to supply it for the record.

[The information follows:]

In fiscal year 1982, States are eligible to apply for six of the seven block grants in the Department of Health and Human Services. (The primary care block grant does not take effect until October 1, 1982.) By the beginning of the third quarter, almost all States were participating in the block grants. Specific data is as follows:

Block grant	States participating	Indian tribes participating	Awards to Mar. 31, 1982 (in millions)
Social services	50	(1)	$1,199.1
Community services	40	35	$111.9
Alcohol, drug abuse, and mental health	49	5	$193.0
Maternal and child health services	48	(1)	$127.5
Preventive health and health services	48	2	$40.6
Low-income home energy assistance	50	117	$1,871.6

[1] None authorized.

HHS BUDGET SUMMARY

Secretary SCHWEIKER. Low-income energy, all 50 States are now operating it. ADAMHA, 49 States are operating it. Maternal and child health and health prevention, 48 States are operating these. Community services, 40 States are operating. So we have passed out the block-grant checks.

On the budget itself, my budget is $274 billion this year. As I am fond of saying, it is the third largest budget in the world. Only the Soviet Union and the United States spend more money than my Department does. It is up $20 billion over 1982. It is up 8 percent over last year, and it is twice the rate of increase in other Departments, which average 4 percent, except for Defense. So, I am running twice the rate of increase in other Departments.

In addition, our spending rate this year is two-thirds of $1 billion a day. In the new budget it will become three-quarters of $1 billion a day. My budget is $56 billion bigger than the Defense budget in the coming year. It will continue to be bigger than the Defense budget for all the remaining years of President Reagan's term.

So, I think some of these facts haven't gotten through the media very well, but they are rather startling and quite overwhelming and rather sobering.

This particular chart breaks down a point the chairman was making earlier. The bulk of my Department's budget is in the entitlement areas. We have another chart later that shows that about 95 percent of the budget is in the entitlement areas, such as medicare, medicaid, social security, AFDC, and SSI.

My share of the budget has been increasing ever since 1950, when HEW was first formed, when it had like 5 percent of the budget. In 1960 it had 15.8 percent of the budget. In 1982 we are up to 35 percent of the budget, and even in the new budget we get another percentage gain, 36 percent. And before the President's term is ended, we will be up to 37 percent. So, my pro rata share of the budget has increased every year since it was founded. It has increased every year under President Reagan.

Senator SCHMITT. Does that assume enactment of entitlement reforms?

Secretary SCHWEIKER. Yes.

Senator SCHMITT. So, even with the President's proposals for entitlement reforms, we will see it increase.

Secretary SCHWEIKER. And without it, you will see a much vaster increase, exactly right.

The next chart rather dramatically shows you how serious the problem is, and since I represent about 37 percent of the budget, it is right here. This is a graph of the increase from 1950 to 1984. In the 1950's, spending for HHS programs went up $12.5 billion. In the decade of the 1960's, it went up $35 billion. In the decade of the 1970's, it went up $145 billion.

The most alarming thing—the thing that really ought to sober all of us up—is that at the beginning of the decade of the 1980's, the first term of President Reagan, it is going up at an even faster rate than it did last decade. Under current law, $108 billion in just 4 years, if you assume current law and if we make no budget changes. But if you leave current law on the books, assuming the rate experienced during the first 4 years will continue through the 1980's, it will go up at a rate of 2.5 times the $108 billion, almost at $270 billion for the decade under a Reagan administration. This is compared to $145 billion in the last decade, and that was a pretty rapid rise.

So, that delineates the problem.

Senator SCHMITT. Is there any argument in the administration as to what the source of the deficit projections under current law is?

Secretary SCHWEIKER.. In terms of what has caused this?

Senator SCHMITT. No; what has caused the overall deficit projections under current law that the administration is living with.

Secretary SCHWEIKER. I am not sure I understand your question.

Senator SCHMITT. Well, it is principally out of this growth, isn't it?

Secretary SCHWEIKER. Oh, the entitlement? No; I don't think there is any argument about that. Let me show you. I have a few more charts that also point this up.

If you eliminate inflation, the curve is still pretty bad. This is the constant dollar program chart based on 1972 dollars, and the figures vary somewhat. Basically it shows the same pattern, roughly, and this is just a constant dollar curve.

Senator SCHMITT. What is the inflation assumption for 1980 to 1984?

ASSUMPTIONS ABOUT INFLATION

Secretary SCHWEIKER. It's 8 percent in 1982, 6.3 percent in 1983, and 4.7 percent in 1984. If we do better than that, which the last few months have been, obviously, we will improve. The next chart shows how difficult it is just to make small changes in the entitlement programs because my base is so large. Incidentally, my Department spends 8 percent of the gross national product in this country, in case there's any question about size.

Here's an illustration. We're making proposals in the entitlement program, primarily in medicare and medicaid—although not only in these areas—which total $6.8 billion. There is not a cutback. It represents a reduction in growth of $6.8 billion, because both of the programs, medicare and medicaid together, will still grow $5.8 billion, even if we assume the $6.8 billion in proposed reforms. So that would still increase $5.8 billion, even if we get a $6.8 billion reduction. It shows how difficult it is to change direction. The dotted line on the chart is based on current law, and if we assume the $6.8 billion in entitlement changes are passed, the curve turns down slightly, as you see.

Senator SCHMITT. It doesn't turn downward. It goes up less fast.

Secretary SCHWEIKER. It goes up less fast. Here's one curve that turns downward, but we're looking at another aspect of it. This chart shows the rate of growth in my Department, and I think this is one thing, if you want to look back at the 1981 Budget Reconciliation Act and see the progress we made there, you can see here for the first time some real progress. This chart shows the year-to-year percentage increase in the HHS budget and the principal areas which are drawing the budget out of balance. When I took over as Secretary in January of last year, spending in my Department was increasing at the rate of 17.8 percent. Because of the Reconciliation Act and the budget that we made last year, the continuing resolution, we knocked that increase down to 10 percent, which is quite a significant achievement, when you're talking about a $250 billion base going up at 18 percent.

Now we've got the growth rate down to 10 percent, which is at least getting in a reasonable area. The budget, if it's passed, would reduce it to about 8 percent. If not, we're still basically at the 10-percent level, a big step from almost 18 percent. I think that's something that Congress and this committee can take some credit for. We have slowed the rate of growth down in my Department. All you can do in my Department is slow the rate of growth. You can't cut it, in spite of the way the media talks, if you're talking about the total dollars involved.

Now here is the total entitlement picture, which basically we're pointing out, Mr. Chairman. The green part is the entitlement portion of my budget. The blue part is the discretionary. Here, as I indicated, $261 billion of my $274 billion budget are entitlements. Discretionary programs are down to 5 percent, and we've squeezed it tighter and tighter. Back in 1970, entitlement programs represented 92 percent of the budget which has risen to 95 percent. And as you can see, we've made progress this year in holding down the blue area which is discretionary spending again and which has gone from 7 percent in 1980 to 6 percent in 1982 to 5 percent projected for 1983. So we've been making progress there.

Senator SCHMITT. Well, I'm surprised you use the word "progress" because it's really in those discretionary programs, Mr. Secretary, where a great deal of the necessary work which you described on your first chart as being your major initiative is going to take place. It's in the discretionary health programs where really the progress for the future wellness of the population is going to be made, and it's important that everybody understand that even though you cut the rate of growth of spending in your Department, it was done almost entirely at the expense of discretionary programs.

Secretary SCHWEIKER. No question. One of the areas that I did argue with OMB on is discretionary health programs. They wanted to cut even more this year, and I appealed that decision and reversed it. They had targeted them for another 10-percent cut, and I felt that was unfair, because they had taken some heavy cuts already. So there's no recommendation for further cuts in discretionary health programs, because I thought we'd gone far enough.

The next chart breaks down the major areas of my Department which your committee considers. The other picture was the whole Department picture. Of course, as you know, the HHS trust fund programs do not go through this committee. Our request for apprpriations do come under the committee and include the Public Health Service, the Health Care Financing Administration, the Social Security Administration, the Office of Human Development Community Services, and departmental management.

GROWTH OF HHS APPROPRIATIONS

This chart shows the growth of HHS appropriations. This is again what your committee deals with. As you recall, of the HHS budget, 95 percent is allocated to entitlement programs which include the trust funds which are not appropriated. HHS appropriations for 1983 total $65 billion, and 82 percent is for entitlements and 18 percent is for discretionary programs. So this is what your appropriation bill covers. This is a dilemma which you find yourself in, since you can only deal with the discretionary 18 percent of your HHS appropriation budget—82 percent you have no say over, unless the authorizing committees enact a change or a reconciliation act is passed.

So I think this shows the frustrating part of your job. When I was sitting there, I found it frustrating. This chart dramatizes the fact that here while you're talking about over $65 billion, barring authorizing changes, you can only touch 18 percent of it, and that's the part we cut already. We did not cut any further in the health areas, because I felt we'd gone far enough.

Senator SCHMITT. Which you have. For 1982 to 1983, your budget proposal cuts another almost $2 billion out of discretionary programs.

Secretary SCHWEIKER. That's right, but not in the health field.

HOSPITAL INFLATION

Now this chart deals with one of our most serious problems—hospital cost inflation. This top line shows how much the hospital cost index has gone up. As you know, it was the worst increase in 1 year in history, and it went up 19 percent, twice as fast as the cost of living. As this line shows, for the last few years, it's averaged 14 percent a year, while the cost of living has averaged under 10 percent. The interesting thing is if you just take the medical index alone, which includes hospitals as a component, it really parallels the cost of living quite closely.

So that the point is, if you take hospitals out of the health inflation, there really isn't much problem, except normal inflation problems. Hospitals are the problem. If we took that element out of it, these curves would almost be parallel.

Senator SCHMITT. Now wait a minute, does the medical care price index exclude hospital costs?

Secretary SCHWEIKER. No; it includes them. So if you took hospitals out, the lines would almost be synonymous. I think that's important. Some things have actually been slower than the rate of growth in inflation, such as pharmaceutical products and dental fees are below the rate of inflation. So health cost inflation is focused exclusively on the hospital problem. Part of it, of course, came from the Government pushing up demand in this area.

Senator SCHMITT. Excuse me, Dick, let me ask one other question. That's the index of costs. What about the absolute per capita costs of care. Are people using hospitals less, or are they using them more? Do you see what I'm saying? For the individual, what does it mean in terms of the annual cost of hospital care or medical care? If you don't know, could you provide that breakout for the record? Are we going to get to that?

Secretary SCHWEIKER. The next chart relates to that issue.

Senator SCHMITT. Go ahead. I'm sorry to interrupt.

Secretary SCHWEIKER. This is an absolute figure which shows how medicare and medicaid are the fastest growing problems in the Government today. The problem is, if we don't deal with the problem now, you're going to have a real problem in about 4 or 5 years. The social security trust fund trustees, of which I'm one, just released our report.

While the health insurance trust fund is in the black for a few years, all of a sudden, whoom, it really goes in the red quickly. At the end of this decade it collapses, and we're going to have to make some drastic changes by the end of this decade for medicare, medicaid, unless we want it to go flat broke.

Part of the reason is that we started out with zero programs in terms of medicare and medicaid in 1965. That's when it all began. Then $12 billion in 1970, $30 billion in 1975. This figure of $63 billion for the two programs in 1980 will triple by the end of the next decade. In other words, if we don't change the beneficiary or entitlement policies of medicare, medicaid, they will grow to a little under $200 billion by the end of this decade. That's why I say that's your next problem, and to some extent, it's even going to be a worse problem than social security, if we don't deal with it now. We have some time now, obviously, unlike social security.

HEALTH INSURANCE

One of the reasons we have problems, and this gets back to your question, Mr. Chairman, is that our health insurance works so well that it hides the dent of inflation in the real cost of doing business. Here's a good illustration. In 1950, it cost $15 a day to go to a hospital. In 1980, it's $245. It's higher than that now, $260 or $270. If you put it in constant dollars, and eliminate inflation, using 1967 as a base, it would be $22 a day in 1950 versus $99 a day in 1980. So in 30 years, the cost of going to a hospital has inflated 350 percent in constant dollars, forgetting inflation. Now one of the reasons it's inflated so quickly is just that back in 1950 about 30 percent of our expenses in hospitals were paid by the patient out of pocket. When an individual left the hospital, he had to come up with the money either in a check or in cash or a bill to be sent to be paid by himself. Insurance paid 70 percent of it. He personally paid out of pocket 30 percent. Today that figure has dropped to 9 percent. So only 9 percent of the cost today is paid by the patient out of pocket. The rest is paid by his insurance company, the employer, medicare, medicaid, anybody but the person involved. I'm talking about direct payment.

If you put that in constant dollars and equate what he was paying in 1950, in 1967 constant dollars he was paying $7 a day out of pocket. In constant dollars today, he's only paying $9 a day out of pocket. So his hospital bills soared in real dollars from $15 to $245. It's only costing him $2 more, in constant dollars, out of pocket. So he feels no pain, because it's passed on down the line. He doesn't really know what's happening. He just knows the bill goes through; he may look at it, or he may not.

That's really the nub of the problem right there. Hospital insurance hides the real cost, and the patient doesn't have much say about it.

Senator SCHMITT. Have you tried to equate the premium costs? Do you see what I'm saying? How much do premiums add to that $9.

Secretary SCHWEIKER. Well, let me say, some 21 percent of the rest of it would be made up of premiums. It would be made up of employer-paid insurance. It would be made up of medicare for senior citizens. So it all depends on the person's status. But, yes, premiums would be a part of it. I pay 40 percent of all the hospital bills in this country right here. So you're looking at the chief payer of hospital bills. So I pick up 40 percent of all the tabs, and you can throw in what the companies pay with their subsidized company plans to the tune of $28 billion a year.

Senator SCHMITT. So it's either taxes or lost wages, because the company pays it, rather than salary, or direct premium. Direct premium being the least now.

Secretary SCHWEIKER. That's right. That's really dropped.

Senator SCHMITT. So the other $90 in constant 1967 dollars is made up overall on the average by the taxes you pay and the wages that are not paid, when you pay the other premiums for employer insurance or premiums you may pay out of pocket.

Secretary SCHWEIKER. That's right.

Senator SCHMITT. So it's not a free lunch. It's just that it's been hidden. So the consumer of health care is not as directly aware of where the money's coming from as he used to be.

Secretary SCHWEIKER. It's been hidden and painless, and because it's painless, it just keeps inflating and nobody gets too excited about it. But come the end of this decade, at the rate we're going, it's going to drop off the cliff. Unlike the social security fund that gives us some time to maneuver and adjust. It's going to drop over the cliff, because of the inflation rate we've got, and I might say, the medical care inflation rate seems worse now, because our average inflation is down the last 4 or 5 months. It's running at 4½ percent. And hospital inflation is still running at about 16 percent. So hospital inflation is running almost 4 times now what our general inflation rate is. So the proportion is worse, even though it's 1 or 2 points.

At this time, I'd like to ask Dave Swoap, my Under Secretary, to come up here for questions. Also my Assistant Secretary for Management and Budget, Dale Sopper, and my Assistant Secretary for Legislation, Tom Donnelly, and we'll be pleased to go ahead and answer questions.

Senator SCHMITT. I'm going to ask our clerk to limit us to 5 minutes, so we all have a chance. I don't know what your schedules are, but that way you can all go around with a series of questions.

HOSPITAL COSTS RELATED TO TECHNOLOGICAL GROWTH

Mr. Secretary, before we get into the prepared questions, I'd like to pursue this hospital cost issue a little bit more. Of course, there is an increase in quality and quantity of service provided by hospitals since 1950, so part of that extra cost is, in fact, buying you something. If you tried to estimate in any way, quantitatively or qualitatively, what you would call the unnecessary increases in costs or undemanded increases in costs——

Secretary SCHWEIKER. I'd better give it for the record, but we estimate there is a 1- or 2-percent technology growth a year in there somewhere too, so you're right.

[The information follows:]

HOSPITAL TECHNOLOGY INCREASES

Over the past 12 years, increases in the cost per day of hospital care have exceeded the increases in the cost per day of goods and services purchased by hospitals by nearly 4 percent per year. We do not know exactly what proportion of this excess is due to increases in hospital technology and what proportion is due to increases in the intensity of services provided. A reasonable estimate might be that 2 percent of the excess each year is due to changes in technology.

INTENSIVE CARE UNITS

Senator SCHMITT. That we're willing to pay for, because we're compassionate and we want to perserve life or extend life or make it more——

Secretary SCHWEIKER. Intensive care units are a good illustration of that. The expensive technology is there. If you have a heart attack, that's where you ought to be.

Senator SCHMITT. But on the other hand, technology also has increased the productivity of the hospital worker, has it not, in the new intensive care units?

Secretary SCHWEIKER. Well, it probably has increased in that area, some, but because they're a smaller segment of the hospital, I'm not sure that the overall figures would be affected much. One of the problems, though, Mr. Chairman, is that doctors are more readily placing people into intensive care units, when they're not really needed. That is an easy way out, because they know they are no risk to anybody. So to some extent, we're overutilizing them.

There is a backlash in this area. By the same token, I am for more intensive care units, and I think that they are worthwhile. But it works both ways. That's technology we do need.

RISING HOSPITAL COSTS

Senator SCHMITT. Well, Mr. Secretary, are you going to give us an answer to how we deal with the national rising hospital costs?

Secretary SCHWEIKER. Yes; we have about four proposals, three of which are on the President's desk now. Dealing with the area of vouchers, for example, is one proposal we have, whereby we would, in essence, let the senior citizen, if he so chooses, take a voucher and purchase the same service from any one of a number of private health plans, to put an element of competition into that area. It would also be a way of bringing the health maintenance organization group plans into more heavy utilization, since they have some cost-effective performance indicators that we feel are justified.

We also have a proposal to give some tax rebates to employees and employers who basically elect to do a little more self-insuring and take a low option instead of a high option plan, and we would protect them with catastrophic coverage. So if they pick a low option plan, they don't get hurt if they fall into a very serious illness situation.

[CLERK'S NOTE.—After reviewing the hearing transcript, the Department clarified its description of catastrophic coverage as follows: "A third proposal would improve the existing medicare benefit package by combining improved catastrophic coverage with some increase in patient cost sharing during the early days of a hospital stay."]

Secretary SCHWEIKER. One of the other areas that we are working on right now, that isn't on the White House desk yet, is prospective reimbursement. Under this system, we would contract with hospitals and providers in advance to provide a certain kind of service for a set period of time for a certain number of people, for say a year. Then that would be the budget constraint that they would have to work with. If they stayed within the budget, they would obviously keep the money as an incentive for efficiency and production. If they didn't, they would obviously be out of pocket. It would put a little more incentive into the system to be cost efficient as opposed to the cost-plus system of hospital benefits that we now have.

So, these are the ideas that we submitted.

EFFECT OF DISEASE PREVENTION

Senator SCHMITT. Mr. Secretary, has anyone in the Department or outside the Department attempted to estimate over the next decade the effect of disease prevention or absolute cure based on modern research and technology developments in contrast to current emphasis on prolonged treatment?

Again, what I am getting at is, Is there any quantitative estimate of the value of the basic research that is going on for which so many Nobel Prizes have been received?

Secretary SCHWEIKER. That is exactly why I have set up this unit at NIH. We haven't formally announced it yet, but it is their job to do exactly that kind of thing. We have some figures now, Mr. Chairman, on such things as alcoholism and lung cancer, that we know are preventable if we do certain things. And you get into billions and billions of dollars. I am not exaggerating when I say $50 to $100 billion in costs and absenteeism. We are trying to put some overall figures together that will go right to the heart of a research effort in this regard. That is one of the reasons I set up the cost data base at NIH.

Senator SCHMITT. Well, certainly, Mr. Secretary, as you know, and we have talked before, we are in the middle of a revolution of understanding in bioscience, which does offer now a potential, unlike just a decade ago, of anticipating disease, preventing it in many cases, and where it can't be prevented or where injury has not been prevented, provided absolute cures. It doesn't require a continuous, prolonged treatment, and I think an issue that the country must examine and be aware of, as well as the subcommittee, is just what is the cost benefit of the basic research that is providing this new opportunity. How much are we really going to be gaining in the next decade through prevention or absolute cure in contrast to what we have had to do in the past; that is, to treat disease over a long period of time?

So, I think it is a worthwhile effort, and I hope you will keep the committee informed of the progress of it. Do you expect to be able to provide reports to the country, as well as this committee, within the next few months or by the next budget cycle?

Secretary SCHWEIKER. We certainly hope to get the whole program formally announced, tied together, and initiated by then. Parts of it are already in place. The NIH program is already underway. We don't have all the facts and figures together yet, but over the next budget cycle, we will be getting all of those figures; yes.

The announcement to the public is going to be done by the Advertising Council.

PREPARED STATEMENT

Senator SCHMITT. Thank you, Mr. Secretary. Your statement will be made part of the record without objection, and it would be my intention, provided there is no objection or any special circumstances, to let Senators take their turn at questions in the order of their arrival at the hearing. If there is no objection, we will proceed with that, and Senator Andrews.

[The statement follows:]

STATEMENT OF RICHARD S. SCHWEIKER

It is a pleasure to appear before you today to discuss the President's budget proposals for 1983 for the Department of Health and Human Services.

This budget for 1983 totals $268.4 billion in budget authority and $274.2 billion in outlays, increases of $16 billion and $20.3 billion respectively above 1982.

The HHS budget consists of authority to spend trust funds, which is not subject to the appropriations process, as well as regular appropriations requests. For the Department's programs considered by this Committee, our appropriations request for 1983 is $65.5 billion.

We are in addition requesting $.6 billion in 1982 supplemental requests, and $5.9 billion as a 1984 advance appropriation, primarily in the Medicaid and Aid to Families with Dependent Children programs.

One significant change in the presentation of our appropriations estimates to you this year is that it assumes passage by the Congress of our legislative proposals to reduce the cost of the appropriated entitlements: Medicaid, Supplemental Security Income, Assistance Payments, and Child Support Enforcement. Without this assumption, our appropriations request to this Committee would be $3.7 billion higher than the $65.5 billion now requested.

The fiscal year 1983 budget and legislative program for the Department of Health and Human Services (HHS) reflects the President's continued commitment to reducing the size, cost and burden of the Federal government, while maintaining the resources necessary to carry out the unique national responsibilities of this Department. This budget builds upon and extends the President's Program for Economic Recovery enacted over the past year.

The key features of this budget, designed to achieve the President's objectives, are:

Reform of Entitlement Programs:

- o An extensive review of the open-ended entitlement programs -- Aid to Families with Dependent Children, Supplemental Security Income, Child Support Enforcement, Medicare and Medicaid -- has resulted in reform proposals which, if approved by the Congress, will save $6.8 billion in appropriations and trust fund outlays in 1983. Social Security Old Age, Survivors and Disability Insurance programs were excluded from this review.

- o The reform proposals included in this budget are designed to:
  - -- eliminate overlapping benefits, inconsistencies and inequities in the Aid to Families with Dependent Children program to assure that benefits are available to the most needy, and to create new work opportunities for recipients;
  - -- modify the Supplemental Security Income program to insure that benefits are more closely related to an individual's actual income and circumstances, and to simplify program administration;
  - -- restructure the Child Support Enforcement program to promote more cost-effective administration; and
  - -- limit unconstrained growth in health care costs principally by targeting Medicaid resources to those most in need and reforming coverage policy and provider reimbursement standards in Medicare.

Full Provision of Social Security Benefits:

- o Social Security benefits are maintained at current law levels and include full cost-of-living increases expected to be 7.6 percent in 1982 and 6.5 percent in 1983.

- o No legislative proposals dealing with Social Security financing are included in this budget. The Presidentially established National Commission on Social Security Reform is charged with developing by December 31, 1982 a comprehensive and long-term solution to insure the fiscal soundness of the Social Security trust funds.

Expanding block grants:

- o Last year, the Administration and Congress agreed to consolidate over 25 HHS categorical grant programs into 7 block grants to States. This action resulted in the return of decision-making on priorities to the States, a reduction of 300 pages of cumbersome and restrictive Federal regulations, and decreases in administrative costs.
- o This year's budget represents another step in this direction and proposes to consolidate four additional programs into the Primary Health Care and Maternal and Child Health block grants, and to create a new block grant for Child Welfare Services from four existing categorical programs.
- o Funding for these block grants totals $5.7 billion in 1983.

Maintenance of Federal government commitments:

- o A continuing priority has been accorded to those programs which represent national commitments, or for which a Federal role is unique. These programs cannot be recreated effectively or efficiently in the States or the private sector.
- o Included in this category are such programs as the biomedical and behavioral research activities of the National Institutes of Health and the Alcohol and Drug Abuse and Mental Health Administration; the preventive health efforts of the Centers for Disease Control and the Food and Drug Administration; and the services to disadvantaged children provided by the Head Start program.
- o Funding for these programs is maintained or increased in this budget request.

Close scrutiny of discretionary programs:

o The 1983 budget continues the effort begun last year to reduce or eliminate programs which are less essential, or marginally effective, and those which can best be supported in other ways. In 1982, Congress agreed to a portion of the Administration's proposals in this area, including the termination of HHS support of PHS hospitals and their transfer to community sponsorship or new uses, and reducing Federal funding of health planning and Professional Standards Review Organizations.

o In 1983, we have attempted to emphasize only the highest priorities within discretionary programs, and to reduce funding in lower priority activities and administrative support areas.

Continued emphasis on effective management:

o The Department is intensifying efforts to improve the management of HHS programs in order to control spending, to minimize waste, fraud and abuse, and to enhance stewardship responsibilities.

o The actions which have been taken or are planned include:

  -- A plan has been established to begin collection in 1982 and 1983 of the $3 billion in debts owed to the Department. Improving debt management and collection efforts is a high priority of this Administration.

  -- Special Departmental task forces have been formed to address regulatory problems and to find ways to simplify needlessly burdensome requirements. These task forces will examine regulations which can unnecessarily burden hospitals, ways to streamline the development and review of new drugs while maintaining essential protections, and means to simplify and consolidate reporting and other requirements on the States;

-- Audit activities have been stepped up, with special emphasis on closing out audits with monetary findings which were unresolved for more than six months, as required by law. By September 30, 1981, there were no such unresolved audits more than six months old, and the Department intends to continue to meet this standard.

-- The paperwork burden that HHS imposes on others decreased by 20.3 million hours in calendar year 1981, a reduction of 25 percent from the previous year.

-- Improving the Social Security Administration's (SSA) Automated Data Processing systems to improve service to a growing number of beneficiaries and insure prompt and accurate payment of monthly benefits is a high priority. A comprehensive plan for upgrading these systems has been developed, a copy of which has been provided to the Subcommittee staff.

New partnership with States and localities:

o Earlier this year, President Reagan outlined a comprehensive Federalism initiative to sort out the responsibilities which should be properly assigned to each government level and return to the States those responsibilities better handled by the States.

o Details of the Administration's proposal are being worked out, in consultation with State and local officials.

I will now detail the specifics of the budgets of each of the Department's operating components. Although primary emphasis will be placed on items that come before this Subcommittee, I will discuss other items at times in order to put the HHS budget in a more complete perspective.

PUBLIC HEALTH SERVICE

For Public Health Service (PHS) programs within this Subcommittee's jurisdiction, we are requesting appropriations of $6.8 billion.

The budget continues the program priorities and health goals implemented over the past year by the Administration. Those priorities include maintaining a strong research capacity, increasing the authority and control of States over the use of Federal health funds through block grants, and preventing disease and promoting public health.

Health Services Administration

Block Grants

Last year, the Congress established a Primary Care and a Maternal and Child Health (MCH) Block Grant. The 1983 budget and legislative program proposes to expand both of these block grants and to fund them at a total level of $1.4 billion. The major changes from 1982 are:

- o Expanding the current Primary Care Block Grant, which now consists only of the Community Health Centers program, to include the Black Lung, Migrant Health, Family Planning and Primary Care Demonstration Programs. This will allow increased flexibility for the States in the administration of closely related programs. The 1983 budget requests $417 million for this block grant, approximately the same total level as in 1982 for these programs.

- o Including the Women, Infants and Children (WIC) special supplemental food program, now administered by the Department of Agriculture, in a revised Maternal and Child Health block grant to be called Services for Women, Infants and Children. A funding level of $1 billion is requested. By combining WIC with the existing MCH block grant, the States will have the ability to target both health care programs and nutrition services to the most needy mothers and their children. This process will be facilitated because most current MCH clinics are also WIC distribution centers.

National Health Service Corps (NHSC)

The 1983 budget of $103 million will maintain the current field strength of 2,915, which includes 2,115 Federally salaried assignees. The NHSC provides physicians and other health personnel in health manpower shortage areas. These individuals provide direct services to geographically isolated and low income people, including migrant workers and Native Americans. In addition to the Federally salaried field assignees, approximately 800 individuals will be participating in the Private Practice Option (PPO) programs sponsored by the NHSC.

Centers for Disease Control

Disease prevention and health promotion are central to the Administration's health policy. The Centers for Disease Control (CDC) is the principal public health agency responsible for detecting, controlling and preventing infectious and chronic diseases and health hazards associated with the workplace and the environment. CDC has the unique capacity to identify and effect containment of disease outbreaks that can spread across State lines, to respond to health emergencies, and to establish scientific standards for laboratory diagnostic materials, disease screening and epidemiological methods. The 1983 budget request for CDC is $217 million.

Immunization

Dramatic gains have been achieved in childhood immunization efforts in the last few years. For example, the number of cases of measles dropped by almost 80 percent in 1981 from the level reported in the prior year. In 1983, $29 million is requested for grants to States, and for surveillance and technical assistance efforts to support immunizations against vaccine-preventable childhood diseases, such as measles, rubella, mumps, pertussis, tetanus, diphtheria, and polio. Through CDC's intensive efforts, the national goal of immunizing 90 percent of all U.S. children against the major childhood diseases has been exceeded with approximately 95 percent protected. Activities are now directed to the maintenance of these immunizations levels.

National Institutes of Health (NIH)

In 1983 the Administration's commitment to the maintenance of an excellent national biomedical research program will continue with a $3.7 billion NIH budget. Health science research is extremely dependent upon public support, with the Federal government providing over 60 percent of the necessary funding. More importantly, 80 to 90 percent of fundamental or basic research is financed by the Federal government, most of which is carried out by NIH. It is through this continued public support of research that major biomedical advances have occurred so rapidly in the past 25 years.

Research Project Grants

The NIH budget request includes $1,857 million, an increase of $37 million, to support 15,141 research project grants, the principal source of funds supporting scientists and research institutions in their conduct of fundamental biomedical research.

Research Training

The foundation of the country's biomedical research capacity is a sufficient supply of well-trained scientists. NIH has traditionally been the primary provider of support for the training and development of young scientists. In 1983, the budget includes $152 million to assist universities in the training of approximately 8,900 scientists.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

ADAMHA is the principal Federal agency responsible for identification of prevention, diagnosis and treatment methods for mental illness, and alcohol and drug dependencies that now cost the American society more than $100 billion annually. The 1983 budget for ADAMHA emphasizes increased funding in the high priority areas of research and research training. Approximately

1,060 research grants will be awarded, including 450 awards for new projects. The 1983 budget request for ADAMHA is $373 million, including $68 million for St. Elizabeths Hospital.

For St. Elizabeths, the budget proposes that an increased share of its costs be borne by the District of Columbia. Currently, approximately 90 percent of the patients at St. Elizabeths are D.C. residents, yet contributions made by the District amount to only 19 percent of the cost of the Hospital's operations. In addition to the $23 million now paid to the Hospital, D.C. will be required to increase reimbursements incrementally so that within three years it will be paying the average hospital per diem to encourage more appropriate out-placement for certain nursing care patients at St. Elizabeths. Reimbursements will also increase for all other inpatients, so that at the end of ten years the District will be paying for the full cost of care for all its residents treated at the hospital. In 1983, total reimbursements from the District of Columbia are proposed to increase to $49.6 million.

In addition, legislation will be proposed to establish a government sponsored private corporation that will administer the hospital.

Health Resources Adminstration

Health Planning

Consistent with the Administration's policy to eliminate Federal involvement in State and local health planning and to implement health care financing reforms, no funds are requested for State and local health planning activities in 1983. The $2 million that is included in the budget request will be used to complete phase-out activities.

Health Professions Education

The 1983 budget request includes $117 million to support the training of health professionals. These funds are exclusive of student loan activities and the National Health Service Corps which are budgeted in the Health Services Administration. The request will be used to focus on the priority needs to:

- Support the training of physician and non-physician specialities where problems persist, such as primary care professionals.
- Enhance the distribution of health professionals to provide better access to health services for people living in remote or underserved areas.
- Encourage minorities to choose careers in the health professions.
- Improve the utilization and distribution of nurses.
- Encourage training opportunities for physicians in preventive medicine.

Office of the Assistant Secretary for Health

Block Grants for Prevention and for Alcohol, Drug Abuse and Mental Health

The request in 1983 of $82 million for the Preventive Health Block Grant and $432 million for the Alcohol, Drug Abuse and Mental Health Block Grant would allow states to continue to support these activities at the 1982 funding level.

In 1983, the Department plans to transfer the management of these two block grants to the Office of the Assistant Secretary for Health. The transition to block grants has been fully implemented in these two programs, and this shift in administrative oversight and consolidation will permit more efficient use of Federal staff resources.

Health Statistics

The request of $40 million for the National Center for Health Statistics (NCHS) reflects an increase of $3 million over the 1982 level of $37 million. The Center is the national source of data on illness and disability; utilization of health care services; health resources; vital events (births, deaths, marriages and divorces); health care costs; and health financing. This statistical information is used by the government, the health industry, business, academic and research organizations and individual citizens to assess health status and plan for health services needs.

Adolescent Family Life

The budget request for the Adolescent Family Life program is $16 million for 1983 and $11 million in 1982 of which $10 million is a supplemental request. The program will provide 60 grants in 1982 for demonstration projects and research studies to carry out legislative mandates to: avert pregnancies among single teenagers, work with pregnant teenagers and their families to ensure a healthy pregnancy and a healthy child, and help pregnant teenagers continue their education. The $5 million increase in 1983 will provide for an additional 30 grants for demonstration projects and research studies.

Smoking and Health

The request of $2 million for the Office on Smoking and Health would continue the 1982 level of activities to reduce smoking and its adverse impact on health. This program works to reduce the 345,000 deaths annually associated with smoking. Over the years, Federal government attention to the hazards of smoking has been correlated with reductions in the numbers of smokers.

Health Promotion

The request of $2 million for the Office of Health Promotion includes an increase of $1 million over the 1982 level. Prevention activities have been identified as the most promising area for future improvement in the health status of the Nation. The Office is working successfully with State and local governments, voluntary organizations and businesses to increase the level and effectiveness of their health promotion efforts. The $1.1 million increase would provide for an expansion in the National Health Information Clearinghouse to provide up-to-date information on disease prevention and health promotion. It would also provide an increase for the National Health Promotion Training Network's support of the health promotion efforts of non-profit health organizations.

HEALTH CARE FINANCING ADMINISTRATION

The 1983 HCFA budget request includes outlays of $68.1 billion from both trust funds and appropriations, an increase of 7 percent over the current estimate for 1982. This increase is due primarily to the estimated effect in 1983 of the continuing rise in the cost of health care. Under current law, approximately 47 million beneficiaries will be served through the Medicare and Medicaid programs in 1983.

The 1983 budget provides for significant savings in the delivery of health care services through a series of entitlement reform proposals that would:

o improve the responsiveness of welfare programs and target Medicaid expenditures on those most in need;

o reform Medicare coverage policy;

o reform provider reimbursement; and

o streamline program administration.

These cost savings efforts will hold Federal health expenditures next year to approximately $4.6 billion below what they would otherwise be.

For HCFA programs which require appropriations action, primarily Medicaid and a portion of the Medicare program, we are requesting appropriations of $32.5 billion in 1983.

Medicaid

The 1983 appropriations request for the Medicaid program is $17 billion, including the impact of proposed legislative savings of about $1.9 billion. Our request excludes funding for State and local administrative costs which are included in a "Combined Welfare Administration Fund" in the budget of the Social Security Administration. Overall, the 1983 Medicaid request is the same level as 1982 once a comparable adjustment is made for the transfer of these administrative costs.

The budget also requests a supplemental appropriation of $553 million to meet anticipated Medicaid costs in 1982. The fourth Continuing Resolution (P.L. 97-161) provides for outlays of $17.3 billion for the Medicaid program in 1982. Based on the November State estimates, Medicaid outlays under current law are projected to be approximately $18.1 billion in 1982. Although several of our 1983 legislative proposals, if enacted as requested by July 1 of this year, will reduce 1982 needs by approximately $280 million, an additional $553 million is required to meet the total anticipated Medicaid costs.

Payments to Health Care Trust Funds

A total of $15.4 billion is requested for Payments to the Health Care Trust Funds, an increase of $1.1 billion over 1982. Most of this increase is for Federal matching of premiums paid by or for individuals enrolled in the Supplementary Medical Insurance (SMI) program. The growth in the Federal payment for the SMI program is due primarily to rising program costs, statutory limitations on premium increases, and the need to keep the program actuarially sound.

Program Management

The budget request includes $89 million of appropriations, together with $846 million of trust fund transfers to administer the Medicare and Medicaid programs. Highlights of HCFA program management activities include:

- Professional Standards Review Organizations (PSRO). As part of the Administration's commitment to reduce the regulatory burden on the private sector, legislation will be resubmitted to eliminate the requirement for PSRO review of Medicare services. It is anticipated that PSROs that have demonstrated their effectiveness will be able to continue operations by marketing their services in both the private and public sector.

- Medicare Contractors. The budget request for 1983 is $704 million. The request reflects HCFA's continuing efforts to implement program efficiencies, including the application of new ADP technology. These efforts are expected to allow the program to accommodate increased workloads within the requested level.

  In addition, legislation will be introduced to eliminate the ability of providers to nominate their own contractors and to provide HCFA additional flexibility in the choice of contracting arrangements with intermediaries and carriers. This reform would allow the selection of a contract arrangement, such as a competitively bid, fixed-price contract, which will produce the most economical results in a variety of circumstances.

- Research. The 1983 request of $30 million for research and demonstration activities is an increase of $500 thousand over the 1982 level. This increase, along with $4.5 million to be reallocated from the 1982 base, will be directed toward new projects designed to explore ways of fostering competition in the health care market.

- Administrative Costs. The budget request of $182 million in 1983 includes a savings of $15 million from a personnel reduction of 730 full-time permanent positions. These reductions reflect the Administration's continuing effort to streamline and improve the management of Federal programs. Studies are currently under way that will provide the basis for an allocation of staff resources that will enable HCFA to continue to carry out its essential tasks in the most efficient manner.

The decision to reduce HCFA personnel was made prior to the President's announcement of his intention to relieve States of the financial burden of Medicaid. An analysis is currently underway to determine the most effective way of implementing this proposed change in policy. HCFA personnel requirements will be an important part of this analysis.

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) operates the Department's income security programs for the aged, disabled and poor. Estimated program outlays of $192.5 billion in 1983 constitute about 70 percent of the HHS budget. About 49 million people will receive assistance from these programs in 1983. Of the total SSA budget, $21.0 billion represents appropriations requested of this Committee.

I would like to summarize for you now the major components of the Social Security Budget, including highlights of the trust fund benefit programs.

Social Security Benefits

Social Security trust fund outlays will increase by $15 billion in 1983. Continued growth in program costs is due largely to two factors: expanding beneficiary population (up over half a million in 1983), and higher benefit levels, principally due to cost-of-living increases (7.6 percent for July 1982, and 6.5 percent estimated for July 1983).

On December 29, 1981, the President signed P.L. 97-123 which provides temporary authority until December 31, 1982 for interfund borrowing among the Old Age and Survivors Insurance (OASI), Disability Insurance (DI), and the Hospital Insurance (HI) trust funds at the discretion of the managing trustee (Secretary of the Treasury). That provision will enable financing of all benefit payments through June 1983. Without additional interfund borrowing or other Congressional action to put this system on a sound footing, it is estimated that OASI income will be insufficient to cover payment of benefits when due, beginning in July 1983.

To put Social Security back on a sound financial footing and restore public confidence in the system, the President has established the National Commission on Social Security Reform. The Commission will prepare and submit to the President by December 31, 1982, legislative recommendations to insure the current and long-term solvency of the Social Security Trust Funds. For purposes of display, the 1983 budget reflects transfers among the trust funds. However, no specific legislation is being proposed with this budget pending the receipt of the recommendations of the Commission.

SSA is undertaking or continuing several program initiatives aimed at protecting the integrity of the trust funds. In the OASDI programs, a debt management initiative focusing on detecting and recovering overpayments to beneficiaries is estimated to save approximately $500 million in 1983. In the Disability Insurance program, the Congressionally-mandated review of new disability awards will continue, and the review of current disability beneficiaries who are not permanently disabled will be increased.

The OASDI estimates reflect an Administration proposal to provide direct Social Security coverage for all current and future career railroad workers. The basic benefits currently paid to this group under the Railroad Retirement program (but in conjunction with a financial interchange with Social Security) would become regular Social Security benefits. The supplemental pension benefit system based on railroad service would be converted to a private industrial pension plan.

In conjunction with the States, SSA also administers the following income maintenance programs financed from general revenues:

-- Supplemental Security Income (SSI) for aged, blind and disabled persons with low incomes (budget request of $8.9 billion).

-- Aid to Families with Dependent Children (AFDC) principally for needy single-parent families with children (budget request of $5.5 billion).

-- Child Support Enforcement Program which assists States in enforcing support obligations owed by absent parents to their children (budget request of $.4 billion).

-- Low Income Home Energy Assistance which provides block grants to States for aiding low-income people in paying energy costs (budget request of $1.3 billion).

-- Refugee and Entrant Assistance programs (budget request of $.5 billion).

In 1984, the President has recommended a major realignment of Federal/State responsibilities for funding of welfare programs.

While these proposals are being further developed, the the Administration is proposing the following program changes and cost savings as part of its overall entitlement reform program.

o Savings are projected for the SSI program as a result of legislation to relate benefits more closely to an individual's income and circumstances, and to tighten the eligibility requirements for disability benefits. The budget impact of these proposals will be to reduce Federal costs by $.1 billion in 1982 and $.3 billion in 1983.

- Major legislation is being proposed in the AFDC program to strengthen work requirements for able-bodied adults, to count the income of all family members in AFDC households, to eliminate program overlaps, and to promote more efficient program administration. Estimated Federal savings are $.2 billion in 1982 and $1.1 billion in 1983.
- Legislation is also being proposed to restructure the financing of the Child Support Enforcement program, to reward superior State performance and stimulate greater emphasis on holding parents responsible for the financial support of their children. The estimated savings from this and related proposals are $35 million in 1982 and $.1 billion in 1983.
- Legislative changes are being proposed in the Low-Income Home Energy program, including:
  - Broadening the purposes for which block grant funds can be used to include activities previously funded under the Emergency Assistance program (Title IV-A of the Social Security Act);
  - Giving States added flexibility in determining income eligibility requirements and payment levels; and,
  - Reducing Federal reporting requirements.

Combined Welfare Administration Block Grant

Beginning in 1983, a combined payment is being proposed for costs incurred by State and local welfare agencies in administering the major Federal assistance programs (AFDC, Medicaid and Food Stamps). On-going administrative costs will be capped at 95 percent of the 1982 level to take account of the savings achievable by efficiencies available to States under this proposal. Of the $2.2 billion, $1.7 billion is included in this budget request, and $.5 billion will be transferred from the Department of Agriculture. These funds will be made available in the form of a single payment to the States with no matching requirements.

Reduction of Error Rate Tolerance

Under the Michel Amendment to the Department's 1980 Appropriations Act, States are required to achieve a four percent eligibility error rate in Medicaid by September 30, 1982 or be subject to a cost disallowance. State compliance with this target is to be assessed in 1983, with disallowances taken when actual error rate data are finalized.

The 1983 budget proposes to require States to achieve a zero percent error rate by 1986. Under this proposal, the target for 1983 would be revised to three percent, with a two percent and one percent target in 1984 and 1985, respectively. Any State which exceeded the target would be subject to a prospective disallowance based on the latest data available. Eligibility errors result in erroneous State and Federal expenditures and limit our ability to focus resources on those most in need. This proposal is part of the Administration's effort to eliminate waste and target expenditures on the most needy individuals.

Refugee and Entrant Assistance Programs

For the Refugees and Entrant Assistance Programs, an appropriation of $532 million is requested.

Special Federal funding for programs which assist refugees and entrants who have resettled in the United States is authorized by the Refugee Act of 1980 and the Refugee Education Assistance Act of 1980. In 1983, expected obligations for Refugee and Entrant programs total $532 million, down $138 million from 1982. This reduction reflects:

- a continued decline in the number of new refugees entering the United States -- the 104,000 arrivals in 1983 is 113,000 fewer than those admitted in 1981 and 138,000 fewer than those admitted in 1980.

- the transfer to the Justice Department of responsibility for the care and treatment of Cuban and Haitian entrants who remain in the custody of the Immigration and Naturalization Service.
- the first full year impact of new cash and medical assistance eligibility rules scheduled for implementation during the current fiscal year.
- phase-out of special educational assistance which augments regular elementary and secondary education programs.

Limitation on Administrative Expenses

The Limitation on Administrative Expenses (LAE) appropriation provides resources for the Social Security Administration to administer the Social Security programs of retirement, survivors and disability insurance, certain health insurance functions and the Supplemental Security Income (SSI) program for the aged, blind and disabled. For 1982 we are requesting an additional $43 million for this account to supplement the $3 billion contained in the fourth continuing resolution. For 1983 we are requesting $3.4 billion for these purposes.

The $43 million supplemental is needed for 1982 because the Administration's September 1981 budget reduction plan for the Limitation account was in part dependent on legislative changes which were not approved by Congress in its action on the third Continuing Resolution (P.L. 97-92). This additional amount is required to ensure that SSA will have sufficient funds to carry out administrative initiatives, such as accelerating continuing disability investigations, and implementing plans to step up debt collection. .

OFFICE OF HUMAN DEVELOPMENT SERVICES AND OFFICE OF COMMUNITY SERVICES

We are requesting $4.9 billion in appropriations for social service programs to be administered by these Offices in 1983.

The 1983 budget for Federal social service activities continues the effort begun in 1982 to increase State flexibility in the programming and administration of program resources and to simplify Federal administrative and oversight responsibilities.

Block Grants

In 1982, the Social and Community Services Block Grants were created in an effort to increase State flexibility in developing programs to meet their own needs and priorities and reduce Federal regulation and reporting requirements. Consistent with those goals, we are now proposing a Child Welfare Block Grant that would consolidate the Child Welfare Services, Foster Care, Adoption Assistance and Child Welfare Training programs.

For the Social Services Block Grant, the 1983 budget request is $1,974 million, the level recommended by the President in his September revisions to the 1982 budget. This request includes authority for the States to use Social Services Block Grant funds to support ongoing Work Incentive programs and Work Incentive demonstration projects initiated in 1982.

For the Community Services Block Grant, the 1983 budget includes $100 million.

The Child Welfare Block Grant proposal is patterned after the block grant models enacted in 1981, while being sensitive to the needs of the particular population being served as provided for in the Adoption Assistance and Child Welfare Act (P.L. 96-272). This block grant will include limited conditions to assure that important reform provisions in that act receive continued support. The overall objectives of this program are to strengthen families, prevent family break-up, and enable children to remain in their homes. In cases where children must be placed outside the home, the objective is to return these children home as soon as possible; or, when this is not possible, to secure suitable adoptive homes. The budget request for 1983 is $380 million.

Head Start

The Head Start program, which provides comprehensive support services and early childhood development for poor children up to age 5 continues to be a priority of this Department. The 20,000 Head Start classrooms provide nutrition, education, health-related and other social services. Emphasis is also placed on special services to handicapped children and on improving parenting skills of the parents of Head Start children.

The proposed 1983 budget of $912 million, the same level as 1982, will maintain Head Start services at a projected enrollment level of 377,300. Of the children served by this program, 90 percent are from poor families and 10 percent are handicapped.

In 1982, the Head Start budget was increased by $93 million. This increase is being used to both offset the impact of inflation and to initiate quality improvements such as salary increases for teachers, increased staff to decrease class size, and facilities improvements to ensure that projects meet State and local health and safety standards. These improvements will be maintained in 1983.

Aging Programs

The 1983 budget proposes $606 million for State-operated programs which finance nutrition, transportation, in-home and legal services to persons over 60 years old. The budget includes a proposed transfer to HHS of the Department of Agriculture administered food program for the elderly. This transfer is proposed to simplify program administration at both Federal and State levels. Food commodities and cash totalling $84 million will be distributed to the States in the same ratio as awarded in 1982.

Within the total $652 million budget for Aging programs, it is expected that the States will be able to support:

- 670 Area Agencies and 57 State Agencies.

- a full range of community services for the aged, including information and referral, and transportation and counseling. An estimated 3.2 million elderly persons will be served.
- an estimated 607,845 daily meals in both congregate sites and through the home delivery program.
- in addition, grants to Indian tribes will continue to be supported at a level of $5 million.

Rehabilitation Services and Special Institutions

Consistent with the Administration's proposals regarding the Department of Education, the HHS budget includes funds to support Rehabilitation Services programs ($637 million), the National Institute for Handicapped Research ($26 million), and Special Institutions (American Printing House for the Blind, the National Technical Institute for the Deaf, and the Gallaudet College Complex -- $83 million).

DEPARTMENTAL MANAGEMENT

The 1983 appropriations request for those activities conducted under the Departmental Management heading totals $275 million. Within this total, the General Departmental Management appropriation supports the executive leadership of HHS, as well as specialized staff services performed for all of the Department's operating divisions on a centralized basis. Also included are appropriations for the Inspector General, the Office for Civil Rights, and Policy Research.

That concludes my statement. I will be happy to answer any questions you may have and look forward to working with you on the 1983 budget.

BIOGRAPHICAL SKETCH

RICHARD S. SCHWEIKER

Secretary of Health and Human Services

Born: June 1, 1926 (Norristown, Pa.)
Education: 1944, Norristown High School (Valedictorian)
1950, B.A., Pennsylvania State University
(Phi Beta Kappa)
Military Service: 1944-46, served as electronics technician
aboard aircraft carrier
Married: 1955, to Claire Coleman (five children)
Business Experience: 1950 to 1960, president of nation's
largest ceramic tile manufacturer
House of Representatives: 1961 to 1969 (13th District, Pa.)
Senate: 1969 to 1981

With 20 years Congressional experience in federal health and welfare policy, Richard Schultz Schweiker was sworn in Jan. 22, 1981, as the 14th Secretary of Health and Human Services (formerly Health, Education and Welfare).

Schweiker had served eight years representing Pennsylvania's 13th District in the House of Representatives, and two six-year terms in the Senate. As senator, Schweiker was ranking Republican member of the Labor and Human Resources Committee, ranking Republican member of the Senate Health and Scientific Research Subcommittee, and ranking member on the Appropriations Subcommittee on Labor-Health and Human Services. He was in the unique position of dealing with both authorizing legislation and yearly appropriations in the areas of health, education, welfare, labor and aging, and his expertise in these areas was well-known.

An acknowledged leader in the fight against diabetes, Schweiker was the author of legislation creating the National Commission on Diabetes and the National Diabetes Advisory Board. In addition, the 96th Congress enacted his Medicaid anti-fraud amendment requiring states to use a sophisticated computer system to detect abuse in the Medicaid program.

Schweiker was also the author of comprehensive health care reform legislation, introduced in the 96th Congress, designed to both increase health care coverage and promote cost sharing and increased choice among competitive health insurance plans.

Among Schweiker's other primary legislative concerns in the health field:

— preventive health care
— cancer and heart disease research
— reform of the nation's blood program
— halting federal support for abortions
— legislation combating sickle cell anemia and lead paint poisoning

Schweiker was born June 1, 1926, in Norristown, Pa. to Malcolm Alderfer and Blanche Schultz Schweiker. He attended elementary and junior high schools in Worcester, Pa., and was Norristown High School valedictorian in 1944. He enlisted in the Navy at the age of 17 and served as an electronics technician aboard an aircraft carrier in World War II.

He received his B.A. degree from Pennsylvania State University in 1950, graduating Phi Beta Kappa.

In 1955, he married Claire Coleman (the original "Miss Claire" of the children's TV program "Romper Room"). They have five children: Malcolm C., 23; Lani Lynne, 20; Kyle Claire, 16; Richard S. Jr., 14; Lara Kristi, 11; and one grandchild.

A businessman from 1950 to 1960, he rose to president in the American Olean Tile Co. in Lansdale, Pa., the country's leading manufacturer of ceramic tile. He was active in the local Republican Party as precinct worker and committeeman, and he founded the Montgomery County (Pa.) Young Republican Club.

In 1960, when he was 34, he won election to the House of Representatives, where he served on the Government Operations and Armed Services Committees. He co-authored a book, "How to End the Draft," which presented the formula later used in creating the Volunteer Army. In addition, the "Schweiker Act" of 1965 provided for cash awards to military personnel who suggested money-saving ideas. The Schweiker Act has resulted in savings of more than $1 billion to taxpayers. He was re-elected in 1962, 1964 and 1966.

Schweiker ran for the Senate in 1968 and defeated incumbent Joseph S. Clark. He was re-elected in 1974. In addition to his service on the Labor and Human Resources Committee and the Appropriations Committee, Schweiker served on the Senate Armed Services Committee, the Senate Rules Committee, Joint Economic Committee, Select Committee on Intelligence Activities, Select Committee on Nutrition and Human Needs, and the Technology Assessment Board.

He was selected by President Reagan to be his running mate in the 1976 GOP presidential campaign. In the 1980 race he served as President Reagan's northeast states campaign chairman.

Schweiker has received seven honorary doctoral degrees. Among other honors he has received are: National Association for Mental Health Award (1974); Opportunities Industrialization Centers Key Award (1974, 1977); OIC's Legislative Pathfinder Award (1980); National Society for the Prevention of Blindness Award (1974); Council of Jewish Federations Distinguished Service Award (1978); Pennsylvania Pro-Life Convention Award (1978); the National Association of Independent Colleges and Universities Distinguished Service Award (1980); Dr. Charles H. Best Award, American Diabetes Association (1974); Humanitarian Award, Juvenile Diabetes Foundation (1974, 1977); Juvenile Diabetes Foundation "Man of the Year" Award (1980); PA/Conservative Union "Appreciation Award" (1978); Distinguished Alumnus Award, Pennsylvania State University (1970); Volunteers of America Booth Award (1980); and Honorary Member, Slumbering Groundhog Lodge, Quarryville, Pa. (1970).

January 1981

Department of Health and Human Services

1981 HHS Accomplishments

I. A New National Health Agenda
  A. Wellness
    — NIH Basic Research
    — PHS Task Force: Medical Schools Cooperation
    — Public Education
    — Sodium Labelling
    — Private Sector Programs Being Encouraged

  B. Consumer Choice and Competition Proposals
    — Task Force Options Look to Positive Incentives including:
      - Offer a Range of Choices to Employees
      - Vouchers for Medicare Choices
      - Medicare Cost Sharing and Catastrophic Coverage

  C. Preserved Vital Research at NIH

Department of Health and Human Services

1981 HHS Accomplishments (Continued)

II. Deregulation
  A. Block Grants to States
  B. Phase out Federal Health Planning Role
  C. Started Closing the "Drug Lag"

III. Crackdown on Waste, Fraud and Abuse of Tax Dollars

IV. Transferred PHS Hospitals to New Uses

V. Targeted Welfare Benefits

VI. Reduced Size and Cost of Federal Bureaucracy
  — Cut HHS Employment by 7% or 11,200
  — HHS Travel Expenses Cut by 20%

Department of Health and Human Services

Summary of FY 1983 Budget

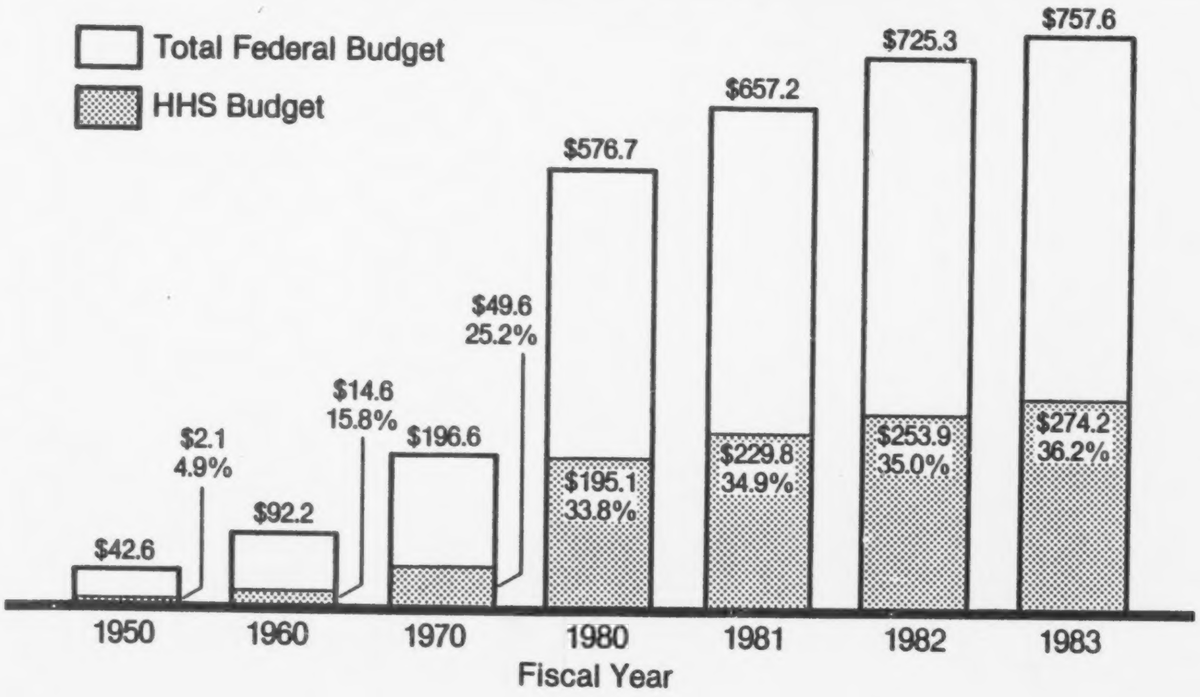
(Dollars in Millions)

	Budget Authority	Outlays
Public Health Service	$ 7,782	$ 8,303
Health Care Financing Administration	67,990	68,052
Social Security Administration	187,464	192,524
Offices of Human Development Services and Community Services	4,931	5,046
Departmental Management/Other	244	240
Total, HHS	$268,411	$274,165

- FY 1983 HHS budget includes increases of $20.3 billion in outlays (8%) compared to 1982.

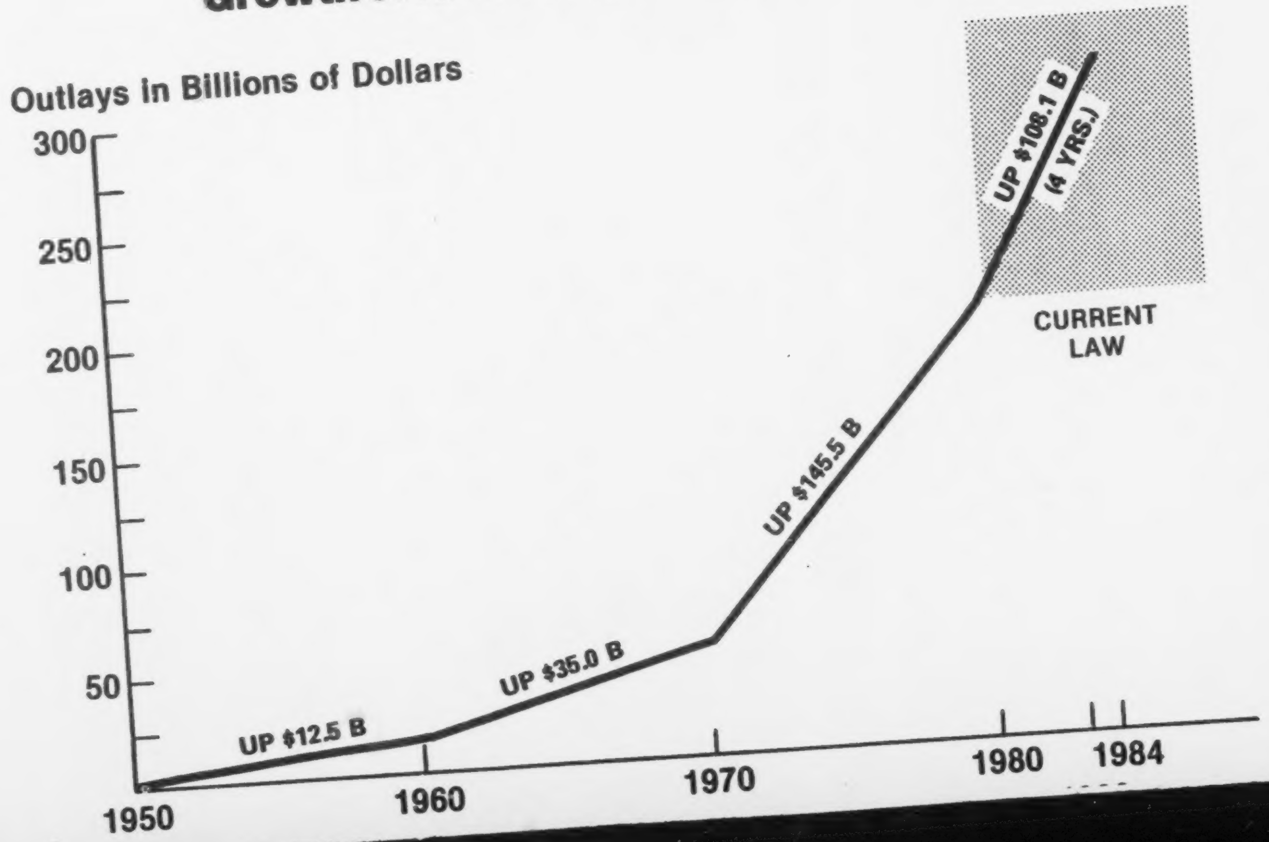
Department of Health and Human Services

HHS Percentage of Federal Budget Outlays in Billions of Dollars



Department of Health and Human Services

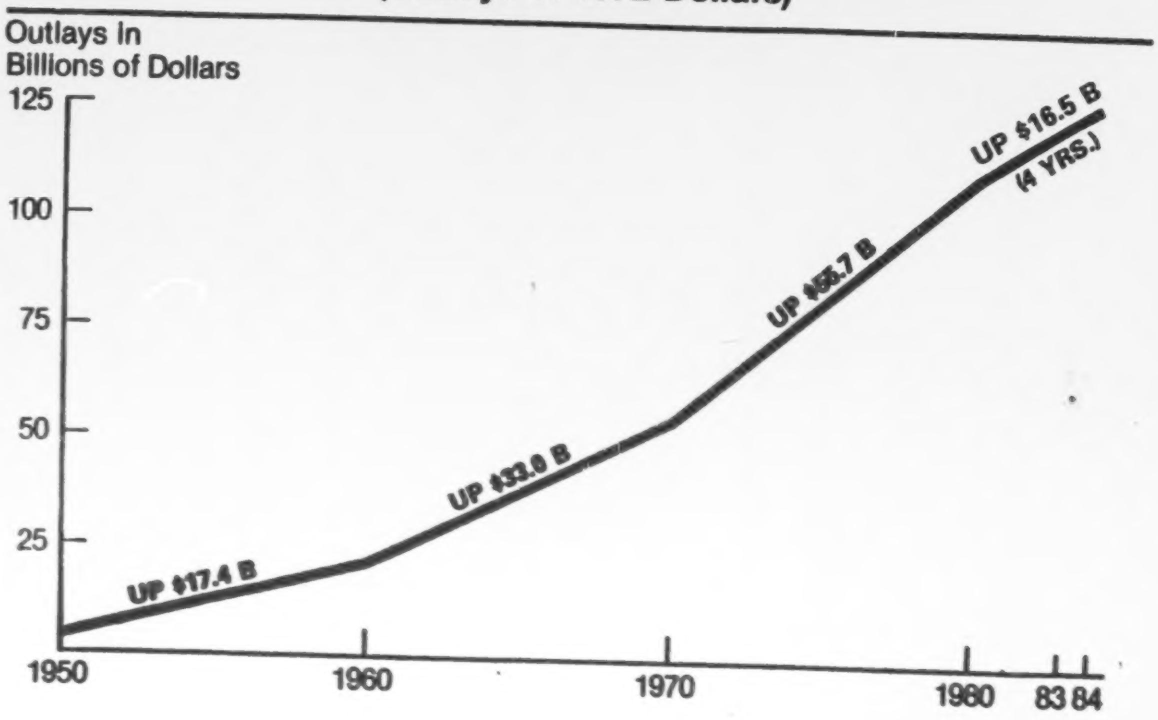
Growth of HHS Programs, 1950 — 1984



Department of Health and Human Services

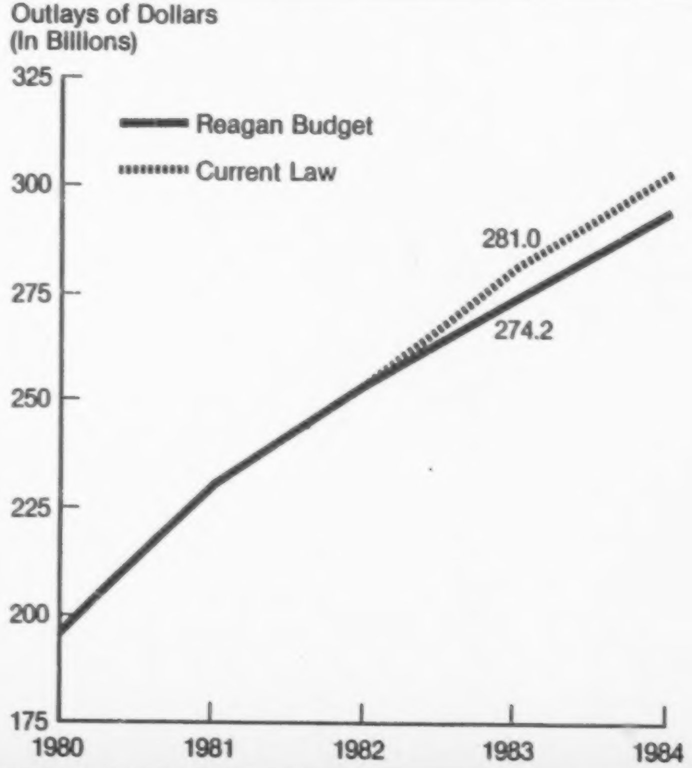
Growth of HHS Programs in Constant Dollars, 1950 - 1983

(Outlays in 1972 Dollars)



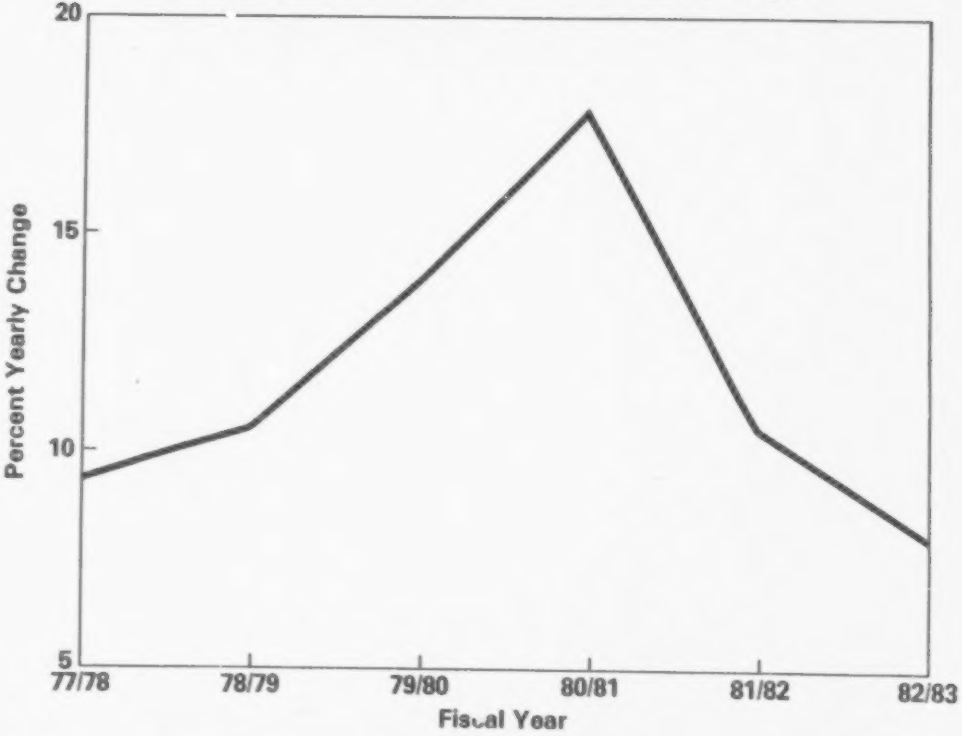
Department of Health and Human Services

Impact of Entitlement Reforms on HHS 1983 Budget, 1980-1984



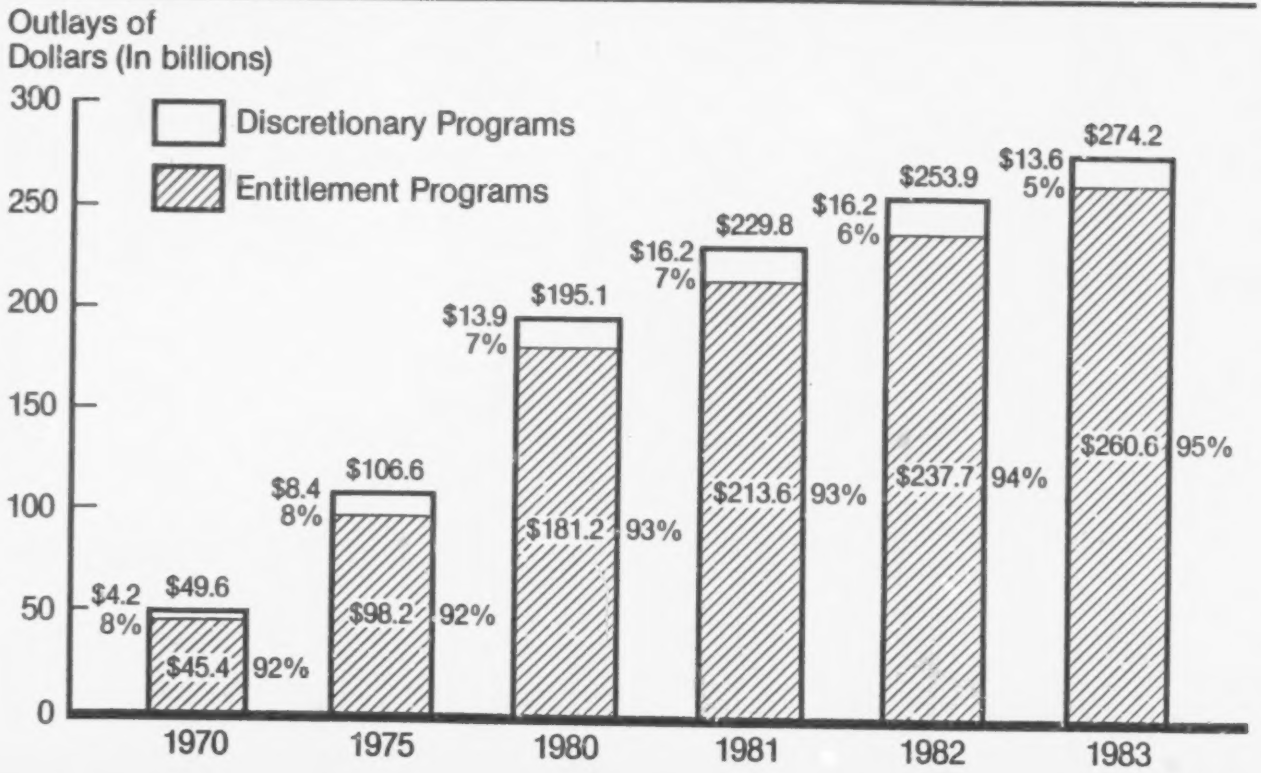
Department of Health and Human Services

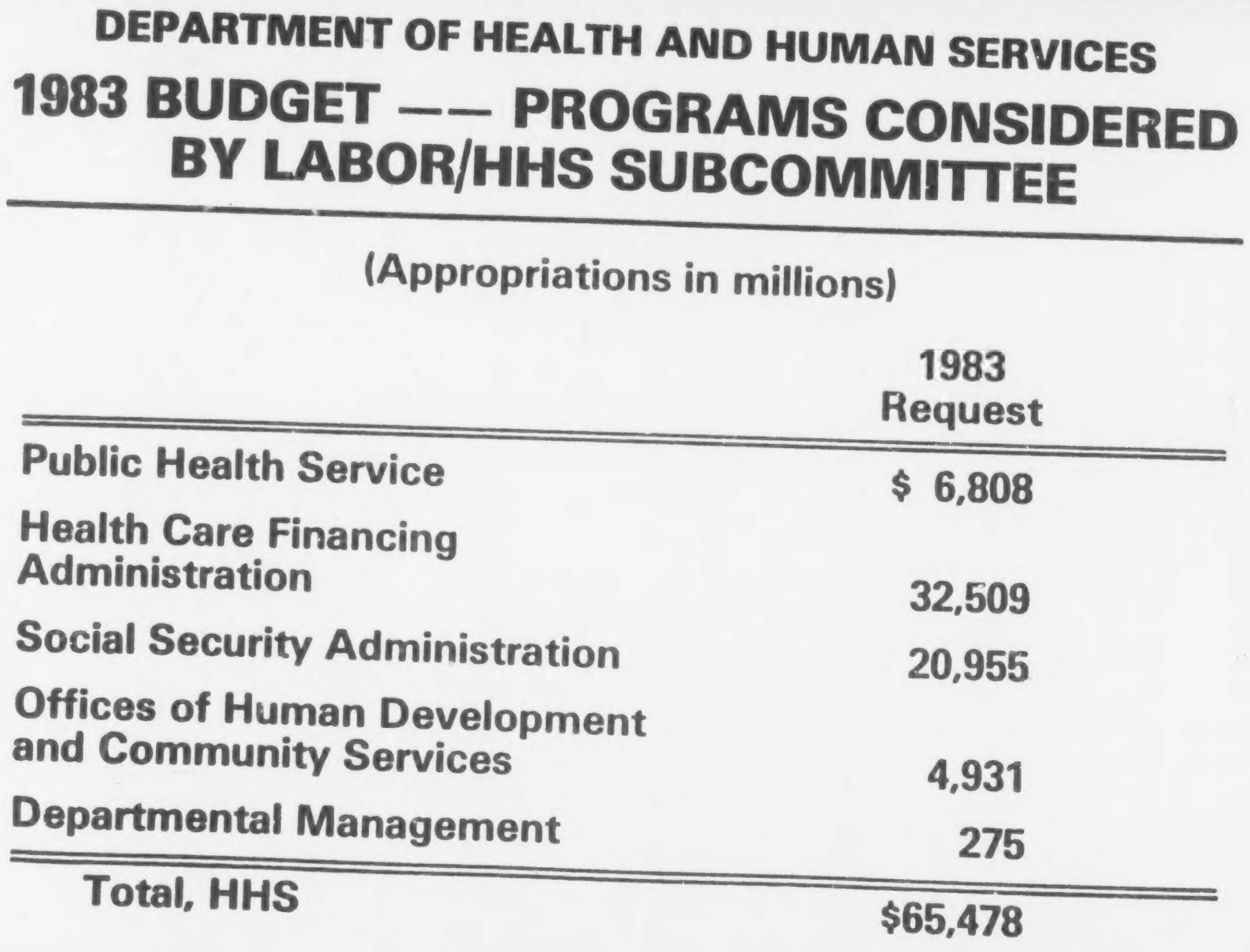
Declining Growth Rate in the HHS Budget



Department of Health and Human Services

HHS Discretionary and Entitlement Programs





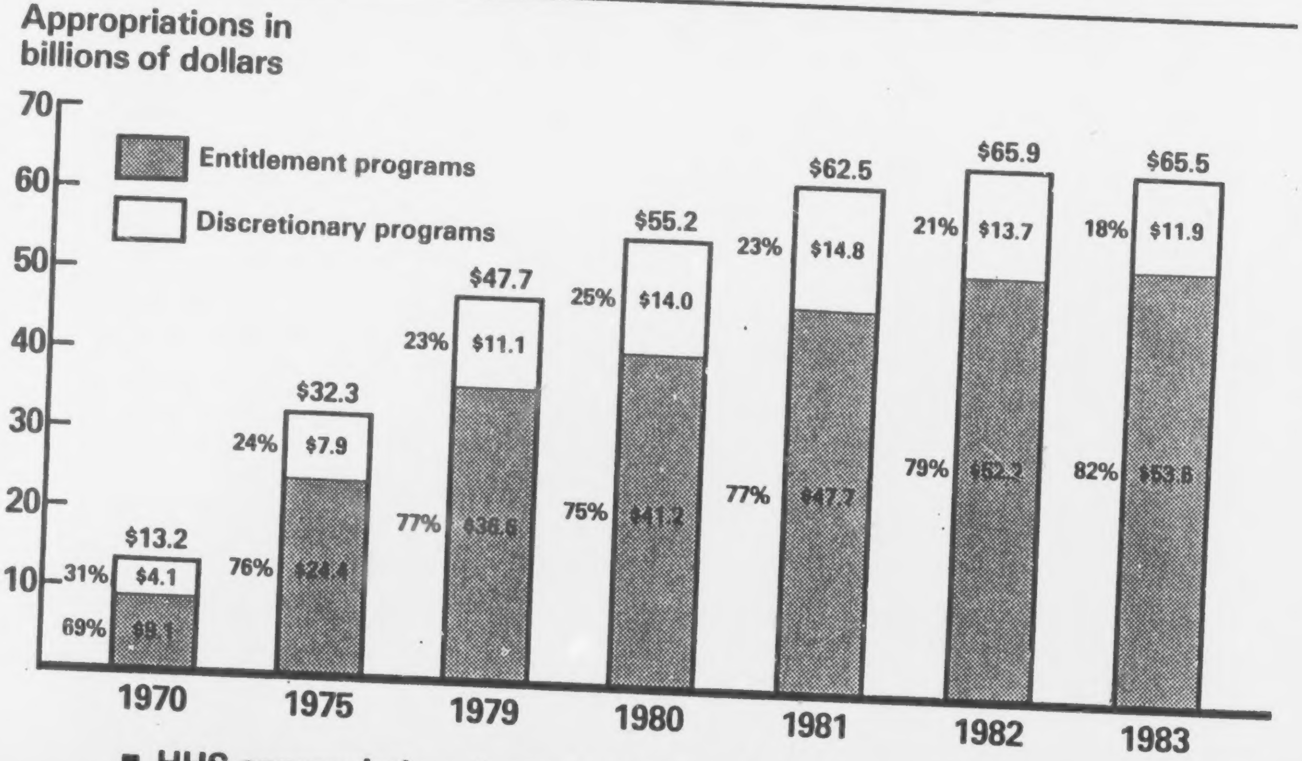
DEPARTMENT OF HEALTH AND HUMAN SERVICES
1983 BUDGET —— PROGRAMS CONSIDERED BY LABOR/HHS SUBCOMMITTEE

(Appropriations in millions)

	1983 Request
Public Health Service	$ 6,808
Health Care Financing Administration	32,509
Social Security Administration	20,955
Offices of Human Development and Community Services	4,931
Departmental Management	275
Total, HHS	$65,478

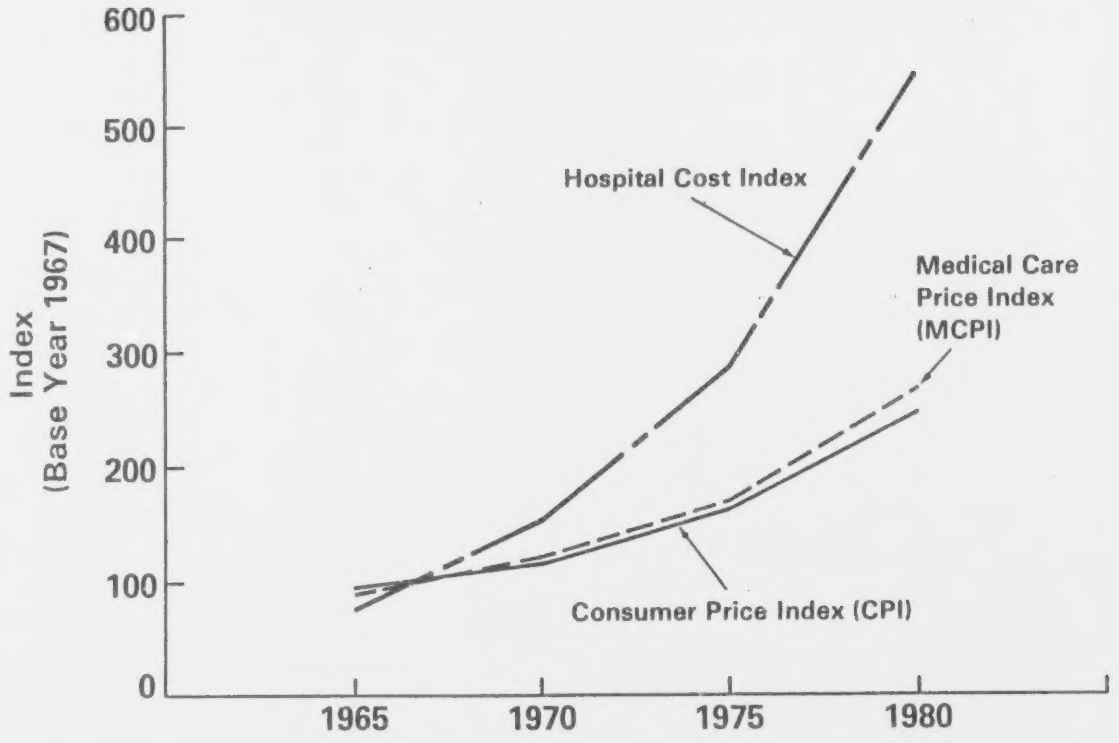
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GROWTH OF HHS APPROPRIATIONS



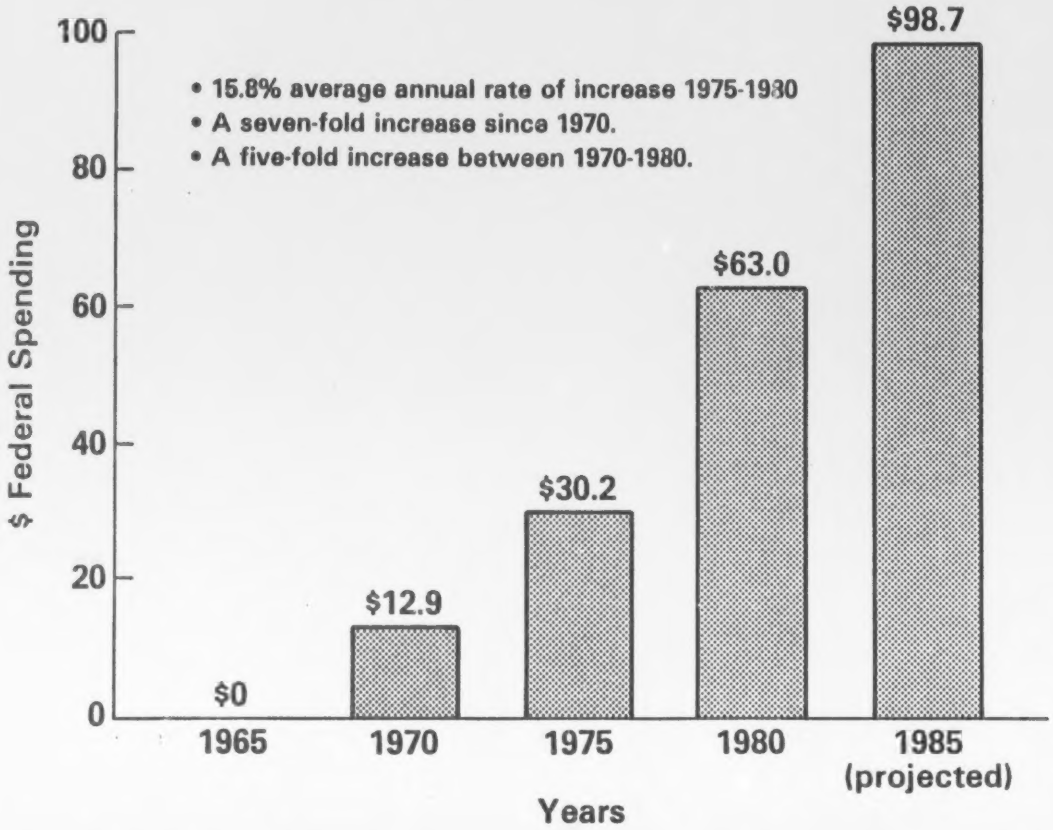
- HHS appropriations increased five-fold between 1970 and 1982

Hospital and Medical Care Cost Increases



	CPI	MCPI	Hospital Costs
• Average annual rates of increase 1976-1981	9.8%	9.9%	14.2%

Federal Spending on Medicare and Medicaid



Insurance Hides the Rising Cost of Hospital Care

	1950	1980
Ave. Cost/Day (Nominal Dollars)	$15	$245
Ave. Cost/Day (1967 Dollars)	$22	$ 99
% Paid Out of Pocket	30%	9%
Out of Pocket Cost/Day (1967 Dollars)	$ 7	$ 9

COMPETITION IN RURAL AREAS

Senator ANDREWS. Thank you, Mr. Chairman. A minute ago, Mr. Secretary, you pointed out that you are going to use vouchers to keep competition and hospital costs under control. In a rural area like North Dakota, there is no competition. We are lucky in some counties to even have a hospital or doctor. You are outlawing PSRO's or you are stopping the PSRO's. What are you going to have to replace that in keeping a cap or giving some cost comparisons on medical care in rural areas?

Secretary SCHWEIKER. Prospective reimbursement. You are quite right, in some rural areas you don't have the competitive element you would have in other areas. So what we would probably do under prospective reimbursement is look at what costs were in rural areas and use that as the basis for prospective reimbursements.

Senator ANDREWS. Could you provide a little more detail on that for the record, Mr. Secretary?

Secretary SCHWEIKER. Yes.

[The information follows:]

RURAL HEALTH CARE PROJECTS

The Department's position is that each community health center, whether urban or rural, is required to demonstrate efficiency in its operation. Indicators of efficiency are used which require each grantee to meet standards on: The percent of total administrative costs including all overhead expenses, 16 percent; the medical cost of providing a medical encounter, $24; and the productivity of physician/mid-level provider teams, 4,200 encounters per year per full-time equivalent. Compliance is expected by the end of the second year of operation.

For the reporting period ending December 31, 1981, the median administrative cost for the 440 rural projects was 16 percent, the median cost per medical encounter was $24; and the median team productivity, 4,253. When the group of projects is narrowed to the approximately 300 projects which have been in operation for at least 2 years, the median performance on the three indicators was 16 percent for administrative costs; $23 per medical encounter; and 4,366 productivity. As each grantee is considered for fiscal year 1982 continuation funding, performance on these three indicators is examined. No 2-year-old grantee which was out of compliance as of December 31, 1981, is refunded unless: The budget and operational plan submitted as a part of the continuation application indicate that the grantee will be in compliance by June 30, 1982, or a waiver of an indicator for a limited length of time is granted for that project because a specific problem is being addressed.

FORMULATING DETAILS

Secretary SCHWEIKER. Let me say that we are still formulating the details.

Senator ANDREWS. I know you haven't come up with a final decision, but I would like a couple or three paragraphs of information on it, because it is a problem.

[The information follows:]

CONTAINING HOSPITAL COSTS

While we have not worked out all the details of a voucher system we do not expect it would work much differently in a rural setting. While there may be fewer health care providers available, there will still be several options for beneficiaries to select the level and scope of coverage.

In the absence of PSRO's, States will continue to be responsible for controlling the utilization of medicaid services. With the enactment of the Omnibus Budget Reconciliation Act of 1981, States have increased flexibility to design a review system that best meets their needs, including contracting with existing PSRO's where they are cost effective.

We are also taking steps to implement a system of medicare utilization review performed by the medicare contractors. Under this approach, contractors would design their own systems based on PSRO experience and their own analysis of provider performance. The incremental costs of using contractors as well as the administrative burden for all involved organizations is relatively low.

VOUCHER SYSTEM

Secretary SCHWEIKER. One thing is, keep in mind, that the voucher system would be totally voluntary. So if a person in a rural area doesn't want to use it, he doesn't have to.

Senator ANDREWS. I know that, but under the PSRO system we had some unique ways of comparing not only costs but quality of care.

Secretary SCHWEIKER. Let me say that the PSRO's are still very much a part of the system. The only difference is that we don't believe that there should be direct Federal support. We do reimburse PSRO's, and if the PSRO's service the hospitals, we will reimburse them. So the point is, PSRO's, as long as they can show that they are economically carrying the load, are reimbursable, and we do reimburse them now under our present system. I am urging even more of that.

Senator ANDREWS. Of course, you are going to provide further details on that for the record.

Another concern folks in North Dakota have is over your proposed new method of reimbursing hospitals for the cost of kidney dialysis for those who suffer end-stage renal disease. I understand that you are putting out regulations that were published, as a matter of fact, on February 12. What has been the reaction to this publication? Have you made a final decision on these regs?

Secretary SCHWEIKER. We haven't made a final decision. We still are getting reactions. I have been criticized from both ends of the scale. I have been criticized by the hospital people because they wanted more of a differential between hospitals and freestanding providers.

By the same token, I have been criticized by the freestanding providers because they wanted a one-shot rate with virtually no difference. I have also been criticized by my Inspector General because he feels I set the rates too high. Providers picketed the building because they said the rates are too low. So I have received all kinds of comments.

This program is running over $1 billion a year. And it is just like any new program we start up. It balloons. So we have to put some constraint on it.

Now, getting back to your rural point, Senator, and I recognize this, we are going to keep a waiver system intact, so that there is a waiver provision for isolated essential facilities. If they can't meet the payments rates, no one will be refused service and we will give waivers to those rural providers that don't have the ability to meet that rate and can justify their costs.

ARMFCO'S CARES PROJECT

Senator ANDREWS. You can expand on that for the record. Let me get in one other question under these time constraints.

At last year's hearings, I spoke to you about ARMFCO's CARES project, a program which coordinated rehabilitation. It really served as an outreach project, as it directed and improved medical care to chronically underserved rural areas in a State like North Dakota.

Have you done other research or studies regarding the efficiency of this type of program? Could you also comment on the rural health care problem?

Those of us in agriculture have looked at the Agricultural Extension Service for years as a kind of an extension service where you send doctors some 300 miles out into the State. It saves Federal dollars. It also makes it possible for those patients in those rural areas, to have the exposure to the specialists, particularly in geriatrics and rehabilitation and things like that. It has been working very well in our State. We kept it last year. We appreciate that.

I was just wondering what your reaction might be to it. Would you see it as a possibility for the future?

Secretary SCHWEIKER. Well, as you know, there was an admission——

Senator ANDREWS. Senator, the primary research and development part has a fiscal year 1982 appropriation of $1.9 million. Our program is, we have been told, the best one. Actually, you could provide that for the record. My time has expired. You can go into it.

Secretary SCHWEIKER. Well, I think we ought to clear up one thing. I am sure you are aware that Congress did put in funds for this. However, we didn't have the authorization to do it. We are asking for the authorization.

Senator ANDREWS. We put in funding for you. The Reconciliation Act left out necessary language that would have provided for rural projects, but you assured me you were finding ways to continue this one, which I am sure you did. I merely wanted an update from you as to your feeling on it, because we think it is extremely cost effective. It saves a whale of a lot of money over transporting these patients.

Secretary SCHWEIKER. We are going to fund it, and we have provided the committee with technical language. We do need technical language that says, "Funds provided by Public Law 97-161 for carrying out section 340 of the Public Health Service Act may be used to fund projects in areas, in nonurbanized areas."

Senator ANDREWS. Right, and you provide us with the technical language so we can get to it in this measure.

Secretary SCHWEIKER. Let me say that we are very receptive to continuing that program. I know you have a very good project in your area in the rehabilitation evaluation services. Quite frankly, if we can get this language——

Senator ANDREWS. That would take care of it. Thank you, Mr. Secretary. Thank you, Mr. Chairman. I have got a couple other questions.

Senator SCHMITT. We will come back in 5 minutes. It won't take very long. Senator Abdnor, you were, I believe, the next arrival.

SWING BED PROPOSAL

Senator Abdnor. Thank you, Mr. Chairman.

Mr. Secretary, I would like to say I had voiced some of the same concerns on your new proposals as to how they might affect rural areas. Both Senator Andrews and myself come from one of the more rural areas in the country. Some areas were very fortunate to even have facilities nearby, let alone having options on who is to use it. So I appreciate the fact that you are fully aware of that, that you do draw up your regulations in this respect.

You know, I am, as one of the prime sponsors, I guess, and movers of the swing bed proposal—are you familiar with that proposal?

Mr. Secretary, how is that progressing? We were a little concerned for a while about some of those early regulations that were being drafted by the Department. As a matter of fact, it looked at first as though they might eliminate from eligibility some of the very hospitals in your area which are experimenting with this program. We have had correspondence in relation to that. I think I had a number of people sign a letter with me, Members of the Senate, who were deeply concerned, because we think it has a lot of potential out in those areas where they could really utilize it with great benefit in those rural hospitals.

As a matter of fact, Mr. Chairman, did you not also write to the Health Care Financing Administration in regard to some of the questions we had, and did you hear from them?

Senator Schmitt. Yes; well, we heard in a hearing that it would be a few weeks. At the time I think it was 6 weeks, which means probably 3 weeks now, and I hope that that schedule is being adhered to.

Secretary Schweiker. Is this on swing beds?

Senator Schmitt. Swing beds; yes.

Secretary Schweiker. We are working to start the operation of this program. We hope we will meet that deadline, and we will also keep on top of it. So there is something in the pipeline now, and you will have regulations available in a few more weeks when we get the program fully started.

FUNDS FOR ADAMHA BLOCK GRANTS

Senator Abdnor. Fine. I am happy to see this getting more attention. Now, as I said originally, in those earlier proposed regulations we had some concerns that may eliminate some of the various hospitals involved that we had in mind when this proposal went into effect. So I am happy to hear that you are paying attention to it.

I am chairman of the Treasury, Postal Service and General Government Subcommittee. That involves oversight and customs. I am very interested in this and made some trips around the country. Drug traffic is a major concern. I just wondered, do you think there is sufficient funds for the alcohol, drug abuse, and mental health block grants to do the job we need to do?

Secretary Schweiker. Well, they took a pretty heavy cut last year, Senator, and I have to be honest and say that OMB came in to cut them again this year. I protested it, appealed it, and won my appeal to level fund it.

Senator ABDNOR. Over about what it was in 1982?

Secretary SCHWEIKER. But they did make the cuts the year before. Some of it was because the programs went into block grants. I would argue very strongly that the research part should not be cut.

I argued that we should preserve the integrity of the research portion of this budget at NIH this time. I appealed and got a further cut forestalled. This is a very serious problem, and I think we still haven't mastered it by any stretch of the imagination.

Senator ABDNOR. Of course, what happens to you after it gets you, particularly with our teenagers. It seems there are no areas of the country that are spared this problem, I will tell you, whether it is South Dakota or any other State, not just New York. Do you think this block grant is going to do the job? I am all for block grants, but do you see some areas, some States?

Secretary SCHWEIKER. I think you can divide the ADAMHA programs up into two sections. There is no question that the research programs cannot be block granted, and that is why I fought for keeping research funding at the level it was.

Most of the programs that we block granted, though, are actually run through the States or by the States through cooperative private sectors. So, to the extent that these were not really run federally, I think that these should still be effective. Now, we did cut them significantly. So I think we will feel some cuts. I don't want to mislead you there, but I think they will be able to be managed in much the same way because they really are run through State groups and private sector groups and coordinators.

Senator ABDNOR. Do you oversee this grant from Washington or is its operation strictly left to States? Do they more or less put their funds in another area and you have no way to follow through on that once it goes to the States?

Secretary SCHWEIKER. So far I think all the States except California have elected to block grant the money. I find that they have a very positive attitude about it. So far we see no indications the money would be used for any other purpose. They are limited to using the money strictly in this area. They do have to make a report.

Senator ABDNOR. They are held to using it in that area, and they very well could probably get more for the dollar maybe.

Secretary SCHWEIKER. I think that some of them are doing one other thing. They are trying to eliminate some of their overhead. For example, Nebraska consolidated its alcohol, drug abuse, and mental health grants into the budget office, so they don't have the overhead. They put more money into the grants that they actually give to the private sector versus the money going to administering the program.

Kansas simplified its procurement procedures. So there are some signs that States are trying to be more efficient, but we really won't know until all the facts and figures come in.

Senator ABDNOR. Thank you. And we are actually ending up doing more for the dollar. I think my chairman is trying to tell me that I've used up my time.

Thank you, Mr. Chairman.

Senator SCHMITT. You'll get some more. Senator Inouye.

PREVENTION AND HEALTH PROMOTIONS

Senator INOUYE. Thank you. Mr. Secretary, I'd like to follow up on where my chairman left off and concur with his support for preventive activities in the health field.

I note here that you are requesting $2 million for health promotion. What do you expect to do with $2 million?

Secretary SCHWEIKER. That's just for the Office of Health Promotion. I think that to get a real picture we'd have to give you the picture from the NIH. Let me see if I can get those figures.

A lot of our research now in NIH is in the prevention area. For example, we just gave a contract to the American Red Cross for a trilateral high blood pressure program to work with black Americans to develop and implement an effective hypertension education program through Red Cross.

We are participating with CDC through the American Educational Research Association in a program that's an attempt to change lifestyle habits, such as smoking, alcohol, stress, obesity, and exercise.

Senator INOUYE. Mr. Secretary, I'm aware of that. Is this an information bureau, or is this the extent of our publicity on preventive health?

Secretary SCHWEIKER. The health promotion figure you mentioned is a small office that we set up a few years ago. You may recall OMB blanked it out in our first budget request. I fought that and it got the $2 million restored.

The Office of Health Promotion is our planning and strategy office. I guess you weren't here, Senator, when I said that one of the things we have done is to persuade the Advertising Council of America to make this one of their three public service projects for the year.

We hope to see a full prevention project put forth as a public service program in many areas. We are developing it now with the Advertising Council of America, so we hope to get maybe a tenfold or twentyfold increase in that investment in free public service announcements by the Advertising Council. This is my top priority.

In addition, $4 billion is being spent at NIH and 20 to 25 percent of that money is really spent in prevention research.

To say we're spending $2 million on prevention is totally a misnomer because of $4 billion, at least 25 percent of that money is going for preventive health research, which is almost $1 billion.

Some of it's going into cancer and smoking areas; some of it's going into the heart disease area; some of it's going into diabetes. We have another project now at the Center for Disease Control which has a model program on diabetes in terms of earmarking diabetics for State control programs so they can control their lifestyles before they get in a diabetic coma, heart attacks, and other problems.

So there are millions of dollars in prevention throughout the Department. We have a catalog figure that I'll be glad to get you; the $2 million is for just a strategy-planning office.

Senator INOUYE. That's what I wanted to know. I wanted to know what they do for $2 million. Recently I was advised that 20 percent of patient visits to doctors are related to lung ailments—respiratory problems—and a significant number are concerned with emphysema, bronchitis, lung cancer.

And I think there's a general consensus in the medical community that smoking has something to do with this. You say here that this program referred to as smoking and health works to reduce the 345,000 deaths annually associated with smoking, and there's a request for $2 million.

What do you hope to do with $2 million versus nearly $1 billion in tobacco ads?

Secretary SCHWEIKER. Again, this isn't the total picture. I think you'll find that at the Heart, Lung, and Blood Institute and you'll find that at the Cancer Institute, we're spending millions of dollars in research on smoking. I'll have to get you those figures for the record.

The $2 million is basically our overhead to determine how we target. For example, we conduct symposiums; I spoke at a smoking or health program up in New York—a symposium for which we were the catalyst.

The American Heart Association, the American Lung Association, the American Cancer Society—we put them together to launch an antismoking program. We were the catalysts to bring groups together like this.

We provide some advertising and some television ads with this money, but the big part of it would be in NIH, in research on lung cancer and on heart disease.

Senator Inouye: Mr. Secretary, I have several questions here.

Secretary SCHWEIKER. Let me say this, Senator. OMB blanked out this program the first time around, and I appealed it and had it reinstated.

Senator INOUYE. I have several questions relating to reimbursements—nurse-midwives, mental health practitioners, et cetera—I wish to submit to your office for your consideration and response, if I may.

Senator SCHMITT. They will be submitted. I hope the Senator can be with us this morning; we'll be again back in session this afternoon with the Secretary.

Mr. Secretary, how does the Department intend to generally evaluate the effectiveness and efficiency of State government operation of the block grants?

Secretary SCHWEIKER. I think I owe Senator Inouye a little better answer here, and I have some figures. for example, the Cancer Institute figures. They're spending some $10 million in cancer research on smoking. The Heart, Lung, and Blood Institute estimates $9,550,000; Environmental Health is spending $1.3 million in smoking research; the Child Health Institute is spending $1.7 million.

The drug abuse section of ADAMHA is spending $2.2 million. There is $25 million in research that we feel is directed toward smoking, aside from the $2 million that you talked about. Sorry, go ahead.

EVALUATION OF STATES OPERATION OF BLOCK GRANTS

Senator SCHMITT. Thank you, Mr. Secretary. As I said, how does the Department intend to evaluate overall the effectiveness and efficiency of State government operation of the block grants?

Secretary SCHWEIKER. Well, it's probably premature, Mr. Chairman, to really give you a definitive answer because of the reporting cycle. So far we've had very few complaints; so far the groups that normally receive the money have not been upset or unduly alarmed about the way it's being handled. So far the indications are good, but I have to say that we're only a portion of the way through the year. A lot of the reporting comes after the fact. We don't have a clearcut answer, but so far we have heard a minimum of complaints in this area, which from my standpoint, is probably a good thing.

Senator SCHMITT. Do you have some kind of a formal mechanism by which you're assimilating reports or gathering them or spotchecking the administration of block grants?

Secretary SCHWEIKER. We do it several ways. We have an analysis of block-grant applications and preexpenditure reports. That's what I gave you the answer from so far.

I've been running a survey of my regional directors to get their opinions in the regions as to what's happening. I've worked with the National Governors' Association in auditing what's happening, and the GAO is doing a study.

Again, so far, we don't have any major problems. I don't say that lightly.

BLOCK-GRANT OVERHEAD EXPENDITURES

Senator SCHMITT. I received some complaints from individuals in States who are involved in the provision of services, that the overhead expenditures to State governments are cutting into the funds available for providing services; that not all States are reducing their overhead commensurate with the reduction in the Federal requirements and overhead.

Are you seeing any sign of this, generally? Are these individual circumstances, or what are you thinking of doing to insure that the administrative savings that are theoretically possible under the block grant are, in fact, being utilized by the States in order to minimize any impact on the provision of services?

To put it more bluntly, it's very difficult for Governors to fire people.

Secretary SCHWEIKER. In the prevention area, there's a legal limit that the States can't spend more than 10 percent for administration; in the ADAMHA block there's a legal limit that they can't spend more than 10 percent.

Senator SCHMITT. But you know, we went through this before. It's awfully hard to determine what's administrative and what isn't. That's pretty gray.

Secretary SCHWEIKER. Except that one has to be a grant process as opposed to administrative. Low-income energy assistance has a 10-percent limit on administration, community services has a 5-percent limit. We are certainly going to oversee these.

Now, there are three blocks that don't have limits. In primary care, we have a provision that no Federal funds can even be used for administrative costs, so there are only two blocks that don't have some limits: social service block and a maternal and child health block.

AMENDMENTS TO LIEA, MCH, AND PRIMARY GRANTS

Senator SCHMITT. Mr. Secretary, we've heard that the administration may propose to amend several provisions of low-income energy assistance, maternal and child health, and primary-care block-grant statutes that it considers burdensome to State governments.

What is the status of these potential amendments? These have to do with further restrictions on administrative costs, removal of program earmarks, and repeal of matching costs, et cetera.

Secretary SCHWEIKER. My information is that the maternal and child health bill actually went up this Monday to the Hill—so that is here. The other ones are still at OMB awaiting clearance.

We have made the request to OMB, but they haven't cleared it for us to release to the Hill yet.

Senator SCHMITT. Would there be any intent to relax restrictions on administrative costs?

Secretary SCHWEIKER. No.

Senator SCHMITT. If anything, you would try to further tighten up.

Secretary SCHWEIKER. I think we will maintain the status quo in all our block submissions.

Senator SCHMITT. Senator Abdnor, would you care for another round? Excuse me, would you yield to Senator Burdick? He just arrived. I'm sorry, Senator.

Senator BURDICK. Thank you, both. Welcome to the committee, Mr. Secretary.

Secretary SCHWEIKER. Thank you, Senator Burdick.

Senator SCHMITT. Senator Burdick, for your information, we're trying to keep roughly to a 5-minute rule.

EFFECTS OF CUTS ON LONG-TERM AND HOME CARE

Senator BURDICK. Fine. I recently chaired a hearing of the Senate Special Committee on Aging in North Dakota on long-term care issues. After hearing firsthand about some of the problems there, I became concerned about the effect of the administration's budget proposals for medicaid. As a result of last year's budget cuts, North Dakota lost about $7 million. Under the proposed cuts in the Federal matching for optional services and for medically needy recipients, it is reduced by another 3 percent.

As the current budget proposes, North Dakota would suffer another major budget cut—70 percent of the services provided under the North Dakota medicaid program are classified as optional services.

Most of the recipients are elderly. What we're talking about is nursing home care and home health care. Those are the services which would have to be cut drastically.

I have a couple of questions along those lines: Does the administration realize how much these reductions might affect long-term care services and at-home care?

Secretary SCHWEIKER. The Senator is correct. We do have some reductions in growth in this program. I had a chart up earlier which showed that medicare and medicaid now cost about $63 billion between the two of them.

In fact you might hold that one up again, if you will. They are the fastest-growing Federal programs we've got, and in the year 1990 will be almost $200 billion.

We really are going through the roof, and the trustees' fund reports show by the end of the decade we'll be in very serious trouble. We aren't now. We're still in good shape now. One of our problems is to restrain growth and yet protect the senior citizens who do need help in this regard.

We are certainly open to ideas on how to do it. We did make some proposals, though I would think the States would still have the right to direct what they wanted toward voluntary care.

We're very sympathetic and supportive of long-term care. We did try to structure the program in a way which would give the States flexibility. But no question, we are trying to slow down the rate of growth.

I think 24 States now cover 20 optional services, including dental services, eyeglasses, and long-term care. It's up to each State to decide what their priorities are.

Senator BURDICK. You see, we think that long-term home care is pretty cost effective. It obviates the necessity of going to hospitals and much of this care can be done very well—to take care of the elderly. The fact that it saves money, I would think that would be one of the places you would not like to cut and shouldn't cut.

Secretary SCHWEIKER. One of our problems in long-term care—and I don't disagree with the point the Senator is making—but one of our problems is cost.

I don't have the exact figure in front of me, but in medicaid, in some areas, 8 percent of the population gets 40 percent of the medicaid funding because it goes into long-term care. So the point is that the proposal is cost effective in one sense.

On the other hand, 8 percent of the people get 40 percent of the dollars. So a State has some very tough choices to make: Whether they give 40 percent of the money to 8 percent of the people or not. That's why we've kept it optional as to how they spend the funds.

We don't want to discriminate against a State using it for long-term care, and that's why we've kept it in the categories of the other 20 optional programs.

I guess New York has a very rich package in this regard and they probably will cover all of it. New York covers 29 and California covers 30 out of 32. So each State somewhat does it differently.

It's not our intent to make it more difficult to buy long-term care because it's a growing problem.

Senator BURDICK. I appreciate the comments, Mr. Secretary, but I just want to make my point that home care can be much cheaper than nursing home care, and in the long run—if we're talking about budget—it seems to me there's an area that we can make some savings.

Secretary SCHWEIKER. Now there are two separate things, Senator. There is a 3-percent reduction in the medicaid programs. The copayment reduction on home health care, which is nominal, is medicare. They do impact, perhaps in the same way.

Senator BURDICK. Mr. Chairman, I ask unanimous consent that I might submit the balance of my questions to the Secretary.

Senator SCHMITT. Without objection.

Senator BURDICK. Since my time has expired.

Senator INOUYE. Your time is up, but we'll have another round just shortly, if you want to stay with us, and we'll be here this afternoon.

Senator SCHMITT. Senator Abdnor.

EFFECTIVENESS OF ELDERLY PROGRAMS

Senator ABDNOR. I'd just like to ask the Secretary a question. Given recent program consolidations and fund reductions, could you please comment on the current effectivness of HHS programs to provide services to the elderly? I guess I'm really particularly concerned in rural areas. Do you think the funding levels you have requested in the 1983 budget, are they adequate?

Secretary SCHWEIKER. You mean for older Americans?

Senator ABDNOR. Yes.

Secretary SCHWEIKER. Senator, we put a high priority on it. We basically made the same request for 1983 as 1982, but because the third continuing resolution required a 4-percent cut across the board, they did get a 4-percent cut. However, I believe they fared better than a lot of the other discretionary programs in my Department. The only cut was 4 percent.

I want to say one thing that somewhat has been lost sight of. We are spending 27 percent of the new Federal budget on elderly Americans. That happens to be $209 billion—that's up from $195 billion last year.

Programs for the elderly went up from 26.9 to 27.6 percent of the Federal budget, so the Federal spending on the elderly has increased nearly a percentage point in its pro rata share. It has increased some $15 billion. So overall it's up $15 billion or 1 percentage point. The particular program you cite has been reduced by 4 percent.

Senator ABDNOR. In what areas do you see most of that increase?

Secretary SCHWEIKER. Well, social security would be the biggest chunk of that—social security, medicare, a portion of medicaid and supplemental security income. It's spread around quite a bit.

But medicare, social security, and SSI would be the areas. In fact, social security is up $11 billion, medicare is up $5 billion, supplemental security income is up $500 million.

Senator ABDNOR. Most of those programs in the Older Americans' Act, then, does that more or less cost the 4, 3, and 2, or is that going to fluctuate according to the program?

Secretary SCHWEIKER. We have other Federal programs that are not in my Department that are affected here. But even with those Federal programs, the increase overall for senior citizens is still $14.4 billion. It's going up.

Senator ABDNOR. Thank you.

Secretary SCHWEIKER. And at the present rate, by 1987 it'll go from $209 billion up to $253 billion, so it's still escalating very rapidly.

Senator ABDNOR. I guess when you add the inflation factor to these programs it can amount to more of a cut than a 4-percent cut, in a sense. Is that right?

Secretary SCHWEIKER. There's no question that inflation's a factor here. However, as I indicated a moment ago, one of the best-kept secrets of this administration is that our inflation rate is down to 4½ percent.

That is 4½ percent inflation versus 12½ percent inflation when we took office. This change is going to have a beneficial effect.

Senator ABDNOR. Thank you.

Senator SCHMITT. Thank you, Senator.

OASH HEALTH BLOCK GRANTS TRANSFER

Mr. Secretary, for fiscal year 1983 the administration has proposed to place administrative responsibility for two of the health block grants within the Office of the Assistant Secretary for Health or OASH prevention on alcohol, drug abuse, and mental health.

What is the reason for putting the administration of these blocks into OASH?

Secretary SCHWEIKER. Well, I think the feeling is that they can be done more effectively within one administrative unit. The idea was to consolidate them under the Assistant Secretary for Health and put them directly under him instead of having pieces farmed out to the Public Health Service.

Senator SCHMITT. Well, but there are other blocks that you're not centralizing. We're just trying to get a feeling for the rationale.

Secretary SCHWEIKER. Only because some blocks are in transition. Ultimately they all will be administered centrally. However, some block programs have a year's transition before they become fully effective. They're optional for 1 year, but at the end of that year they would also be put in the same program.

Senator SCHMITT. So your objective is eventually to have the Office of the Assistant Secretary for Health oversee all the block grants dealing with health?

Secretary SCHWEIKER. That's right. Under him and within that unit.

Senator SCHMITT. What about staff and facilities? Is it adequately staffed for this purpose at this time, or will there be additional requests to staff?

Secretary SCHWEIKER. We made the staffing request in our budget request. In other words, our positions are accounted for in our request.

We believe our budget request is adequate, but we did make some specific requests for some positions.

Senator SCHMITT. And with corresponding offsets in other areas?

Secretary SCHWEIKER. Yes; exactly right.

OASH BLOCK-GRANT ADMINISTRATION

Senator SCHMITT. How do you assure that the expertise and knowledge that maybe exists in CDC and ADAMHA are transferred with the block grants?

Is that a specific effort?

Secretary SCHWEIKER. That's a valid question, Mr. Chairman. In the transition year, we're trying to provide the expertise and the assistance to the States, so that they can run their own programs.

On the other hand, when you get into very technical programs, like TB control and drug abuse treatment, et cetera, we well may still use the agencies to provide backup technical assistance.

I don't want to imply that we won't. In other words, all we're doing is putting the administrative funding mechanism for the blocks in OASH. If the States want some special expertise in implementing our programs, we're perfectly willing to provide that to them from the agency that has the expertise.

What we're really changing is the administration of the fiscal aspects of the program. We'll keep the other agencies available to provide technical assistance through our regular PHS units. We don't mean to ban that.

Senator SCHMITT. Implicit in this, then, is that you do not intend to transfer specific people out of CDC or ADAMHA into OASH along with the administrative responsibilities, and that you would expect that if there is need for their expertise, that they can be put on on a temporary basis to provide that expertise out of CDC or ADAMHA?

Secretary SCHWEIKER. There are two parts: We will be transferring people from the PHS units who are in the fiscal, administrative, and management sector within CDC or ADAMHA to OASH. They would be transferred.

The technical aspects of the program would not be transferred. Those technical people will remain in the program areas, but they will be available upon request to provide technical assistance.

Senator SCHMITT. They would remain technical experts in that area, in the CDC area, ADAMHA, even though they would be working on projects funded from other sources?

Secretary SCHWEIKER. That's right. We would make them available for that use.

Senator SCHMITT. That's a pretty ticklish proposition, isn't it, to make sure they're either not overloaded or underloaded as professionals?

Secretary SCHWEIKER. Again, keep in mind that in this transition year, a lot of the States are gearing up and providing their own expertise, so that by the time the transition year is done, they'll have most of their own expertise.

Some of these programs have already been run by the State health departments. Look at the health block grants—immunization and others. They've already been running these programs for years.

It's not like some of our social services block programs where maybe the State can do it or maybe not. Actually, in most of these areas the health departments are already involved in prevention, in maternal and child health, and actually have run programs like these.

STATE BLOCK-GRANT ADMINISTRATIVE EXPERTISE

Senator SCHMITT. Well, do you see this brings a related question. Do you see a deficiency of experts for the individual States to hire in administering the technical aspects of the block grants?

Secretary SCHWEIKER. So far we haven't had it called to our attention, but we have bent over backwards to provide expertise and free consultation—whatever is needed—to do that. I think that's a very important factor.

If we see there's a problem developing, we will work out some other way of handling it, because I think, obviously, we want to be as cooperative as we can so our programs can succeed. But so far we haven't had these complaints.

Senator SCHMITT. It seems strange that there wouldn't be an infinite reservoir of talent out there for the States to hire in order to administer these programs on the technical side.

Secretary SCHWEIKER. Let's take immunization, for example. We are actually loaning people out of CDC to the State health services now to run the program. We actually loan technical experts to health departments to run their programs. That won't change.

So there are some people that are on our payroll who actually go for a few years to State health departments to run a program, and that hasn't changed. We are providing expertise now in many of these programs—not all of them, but in the technical ones that are really very sensitive, such as immunization. We have already done this, and that practice will not change.

Senator SCHMITT. But how about some of the other areas? We'll get back to this in a moment, Mr. Secretary. Immunization, of course, is something that's been an ongoing cooperative effort between the States and the Federal Government, whereas some of the other programs that are in these two blocks—prevention and alcohol, drug abuse, and mental health—have not always been there in the States. It's not always been a close working relationship between the States and the Federal Government.

Secretary SCHWEIKER. But even if you get into ADAMHA programs, we're not transferring any research funds.

Senator SCHMITT. I understand that, but at the service level there's a great deal of expertise. As you say, with the immunization, that's quite a technical field.

Secretary SCHWEIKER. Yes; that's technical, but in the other areas, we worked mainly through groups in the States anyway. In other words, the grants that we've given out were to grantees in the recipient States. That expertise would still reside there. In some of those cases where the grantee was the State's person, that expertise would still be in the States.

Senator SCHMITT. If you can follow up for the record with any additional analysis that you want.

Secretary SCHWEIKER. We're very open on this. If you show us that there's some extra help needed here, we'll provide it. We won't be in any way tightfisted about it, because I think it's very important.

Senator SCHMITT. We're just trying to anticipate the need, whether or not the budget request is going to be adequate to satisfy that need.

[The information follows:]

PROVISION OF TECHNICAL EXPERTISE

The Public Health Service provides programmatic and technical assistance in a variety of public health arenas. This expertise is available to State and local health authorities according to their expressed requirements. It is authorized under the Public Health Service Act sections describing cooperative disease control efforts between national and local health officials as well as under specific programs such as the health block grants, childhood immunization, and venereal disease control programs. The need to provide such expertise is generally due to the States' inability to fund highly technical expertise or the sporadic need for such assistance.

The extent and duration of the technical assistance provided to the States is determined by the nature of the problem at hand, and the availability of local resources and talents. Federal assistance to States varies from laboratory confirmation of disease diagnoses, onsite assistance for public health emergencies or disease investigations to ongoing program assistance provided by in-lieu-of-cash positions. In the past, the in-lieu-of-cash provision has been used by the States in their lead poisoning prevention programs, the rat control efforts, the health incentive grant program, immunization, and venereal disease control programs. The in-lieu-of-cash provisions in the block-grant authorizations represents the unique flexibility provided to the States as a part of their use of the block-grant funds.

Our current request reflects projected needs as the States begin to fully utilize the block-grant funding mechanisms. We are requesting 63 in-lieu-of-cash positions in fiscal year 1983, an increase of 31 positions over fiscal year 1982.

RUNAWAY AND HOMELESS YOUTH PROGRAM REALLOCATIONS

Senator SCHMITT. Senator Abdnor, would you yield to Senator Specter for his round? We're going on five-minute rounds, Senator Specter, roughly, in order of arrival. Because of the generosity of the distinguished senator from South Dakota, you now are up.

Senator SPECTER. Thank you very much, Mr. Chairman.

It's nice to see you here, Mr. Secretary. I appreciated the letter which you recently sent me with respect to the funding on the runaway and homeless youth program, and I have a special concern about that subject because of the problems that I have seen in connection with my work on the Subcommittee of Juvenile Justice on the Committee of the Judiciary, and I have noticed that the proposed funding level for 1983 is $6.6 million, which contrasts to $10.5 million for the third continuing resolution on an annual basis. Also, I have noted the efforts which you have made to bring volunteers into the program, but have a very deep concern that it just won't stretch far enough given the seriousness of the runaway problem on the national level.

And my question is: Could the resources be stretched further and have more money allocated to that particular line?

[Pause.]

Secretary SCHWEIKER. Senator Specter, I'm looking at the figures to give you exact numbers. [Pause.]

I think it's a good program. I would agree with you that it has a relatively small amount of money.

The original budget request for 1982 initially was cut—I think it probably was a little over 25 percent. This was similar to the other 25-percent cuts that most of the other social services programs in Health and Human Services took.

Then the President asked us to cut across the board another 12 percent in the September amendments and there were no exemptions. So the two cuts were 25 percent plus the 12 percent, and these were enacted in the third continuing resolution.

I can't deny that it's a good program or that it can be used.

Senator SPECTER. Is it conceivable, possible, likely, that there might be some reallocations to put more funding into that particular program?

You have, as I recall it, the third largest budget in the world.

Secretary SCHWEIKER. I also have, as you'll recall, 95 percent of it set by entitlements, which is the problem.

Senator SPECTER. Senator Schmitt and others are going to cure that.

Senator SCHMITT. That's the best prediction I've had today.

Secretary SCHWEIKER. Let me just say that we can certainly look at that figure and see what would be available. We do have a consolidation of research and demonstration projects that might give us more flexibility. We're willing to take a look at the consolidated program to see if we can do a little bit more here. But obviously, we have some constraints in the budget.

Senator SPECTER. Mr. Secretary, I would appreciate it if you would. That has been a subject which has been inquired into extensively, both in my subcommittee and also by Senator Hawkins. And it is a particularly accute problem, and to have that kind of reduction in funding, even though I understand the contraints across the board.

Secretary SCHWEIKER. We'll take a look. One leverage they do have is that it's a consolidated program. We might be able to do some offsetting there; I'll take a look and see if that's feasible.

ADMINISTRATIVE REVIEW OF BENEFIT TERMINATION

Senator SPECTER. Thank you. Have you had an opportunity to note the extensive article which appeared in the Philadelphia Inquirer this past Sunday, Mr. Secretary, concerning those cuts from social security benefits—those who are disabled?

Secretary SCHWEIKER. I saw the headline and just a few of the stories. We're running some of them down, frankly.

Senator SPECTER. I know it is a very difficult matter when you have an administration that covers as many individual cases. It is possible to select out some which are aberrational or which may be a matter of administrative error which simply can't be contained.

But what is your sense of that problem with respect to the tone of the article, which implies that it is a practice and there is not sufficient care on the administrative level, to take the case-by-case specific analysis of those situations before those benefits are terminated?

Secretary SCHWEIKER. Two things: First of all, the continuing disability investigations were ordered by the Congress in the Disability Amendments of 1980. We're just following the law on that, so the mandate clearly was set before this administration came into office.

By the same token, there have been a number of stories about how the investigations are being conducted. I read that particular article. I have set up a task force within Social Security to address problems in the current CDI process because of these specific cases that have been identified.

I am passing on that article in the Inquirer, because it raised some questions in my mind too.

I think it's important that we do the investigation in a fair, evenhanded, and rational way. I do want to go back to the reason that the CDI process was established. I'm sure you are probably aware that the GAO came in and told Social Security that the disability program had a 20-percent error rate and that SSA was awarding $2 billion to people who really didn't deserve it.

The GAO study goes back through 1979. GAO was hitting the Department over the head and saying, "You're wasting $2 billion a year for misawarding 20 percent to these recipients."

Now that we are looking back over the cases we are hearing from the other side of the issue. But the investigation program is evenhanded and fair.

Senator SPECTER. Mr. Chairman, may I proceed for just a moment? I know my time is up.

Senator SCHMITT. Surely.

PROCEDURES FOR TERMINATING DISABILITY BENEFITS

Senator SPECTER. How does it work, Mr. Secretry, procedurally, when somebody is removed from the benefit roles? What action is characteristically taken before that termination is effectuated?

Secretary SCHWEIKER. First we send letters to the individual saying that they are the subject of this review and ask them to provide the names of medical sources. Then after that their medical records and all new medical evidence are reviewed by experts in this area: and, depending on what happens to the medical review, they are either notified that the medical disability is valid and their benefits continue, or they are notified that we believe they are no longer eligible and why. Beneficiaries are then given 10 days to provide additional evidence. No decision is made until we have reviewed any new material submitted.

After a formal notification of the actual decision, they do have a chance at that point to ask for a reconsideration if they want. If the claim continues to be denied, they can request a hearing before an ALJ, appeals council, or the courts.

Senator SPECTER. You say that there is an opportunity for appeal or reconsideration?

Secretary SCHWEIKER. Oh, yes. There is a famous one that the President, himself, was involved in in Virginia just about 1 month ago, where we reinstated this person's benefits. Basically, the review found about 1 year ago that he didn't qualify for disability benefits.

Then he appealed and after almost 1 year of processing time, we had medical experts who found that his situation had deteriorated and gotten worse. So we reversed the decision.

Senator SPECTER. That's the *Kendrick* case.

Secretary SCHWEIKER. Yes; his appeal was successful because the new medical evaluation showed that his situation had deteriorated.

Now, in addition, he would have had the administrative law judge's review and a court review on top of the steps that I have mentioned if his reconsideration appeal had not been decided in his favor.

Senator SPECTER. Procedurally, then, there is a letter which comes from your Department to the individual to notify him. That individual can then have a conference with an administrative officer.

Secretary SCHWEIKER. After the notice comes the medical records review.

Senator SPECTER. The medical records review—when the claimant says he's being unfairly treated and should not be cut off—there's a record review in your department?

At what stage does he have an opportunity to meet personally with somebody from your Department, if at all?

Secretary SCHWEIKER. When he goes to the administrative law judge review hearing, he has an opportunity.

Senator SPECTER. But that is the first occasion when he has a chance to meet with somebody face to face.

Secretary SCHWEIKER. In terms of him coming forth with presenting his case to a decisionmaker, the administrative law judge is the first opportunity.

Senator SPECTER. Secretary Schweiker, it would be my suggestion that it would be useful to take a look at that because the procedures before an administrative law judge are pretty formal.

And at that stage a person usually needs a lawyer; there are papers to be filed—it's a fairly complex matter. I think that it would be very useful if at some stage before it got to the administrative law proceeding, that an individual would have a chance to meet face to face with somebody who is handling the administrative decision, as I have read through some of these in the media reports, and I had some question about that until I saw some of the actual records. Some of them looked very, very surprising: amputation incidents, fingers missing—very substantial medical problems. And it may well be that if there were some face-to-face contact an an earlier stage, that some of the gross errors might be rectified.

It's a very hard process, just in writing, subject to a lot of error.

Secretary SCHWEIKER. Let me say, Senator, that there is a bill that's been reported out of a House subcommittee that deals with this problem—the Pickle bill—and it has 12 provisions. One of the provisions would be to provide a face-to-face reconsideration hearing for medical termination cases.

Senator SPECTER. Could you do that administratively within your own Department without legislation?

Secretary SCHWEIKER. This is one provision of that bill, and so there are some other provisions. I think the action Congess dictated in 1980 was to correct one side of the problem but to some extent, we might have gone too far.

We are looking objectively at the Pickle bill to see whether we might strike a happy balance.

Senator SPECTER. My suggestion would be a very direct one: That is, when a complaint is made and there is any basis, if there's a request made by a claimant for a personal meeting, to schedule it.

In that face-to-face session, I think, a lot of the major errors could be corrected because the person can say what's on his mind, there can be a question, and you can make a factual determination on what matters.

If you're dealing with an amputation matter or fingers missing, if it's the matter of a stomach disorder in some of these cases—then you may need a followup. I've been through the administrative law proceedings and they're complicated, and a person really can't handle himself in that without the advice of counsel.

The administrative law judges, like judicial officials generally, are really looking for counsel, which is an expensive proposition. And I think that if a procedure were instituted for a face-to-face meeting, then this problem could be very materially improved.

Secretary SCHWEIKER. We'll certainly take that into consideration because we are looking closely at the Pickle bill. The Pickle bill does have some constructive areas in it. We don't agree with everything in it, but it's worthwhile looking at it.

Senator SPECTER. My thought on that would be not to wait and see what happens through the legislative process, but that kind of a meeting could be provided for administratively, and I think it would be very helpful.

USE OF INFORMAL HEARING

Secretary SCHWEIKER. Well, again if I get funding for staff to do it—you know, I've got the largest judicial system in the world: I have 750 administrative law judges working for me, and that's just to hear these people the first time around.

If we give everybody an interview, I'll have to set up a whole new staffing operation. I'll need departmental management money. So I agree with the point you're making—I think it's a pretty valid point—but I think we have to look at the budget impact of what we're doing, because you're going to need staff people and money to do it.

As you know, administrative law judges are hearing those cases now. If we're going to let everybody have a face-to-face hearing at the reconsideration level, we're going to at least need as many additional staff as we have for the Office of Hearings and Appeals, and maybe more. Maybe we should.

Senator SPECTER. Secretary Schweiker, what I'm suggesting would save you money. By the time you get to an administrative law proceeding there are a lot of formalistic steps. It's a time-consuming, expensive process to undertake that.

I understand your problem with finding a body who's going to bring people in and spend even 10 minutes with them, but given the legalistic aspect of an administrative law proceeding, I think you would find it a tremendous saving to be able to weed things out before taking it to that level. My suggestion to you is that you take a look at that—that you have to have the personnel to handle the administrative law proceedings.

I've been in those proceedings, and they are involved and there are a lot of papers. I've seen matters administratively in the District Attorney's office—which I used to administer—where people would come in, for example, people on a hearing on a criminal case, which would be very analogous to a proceeding before a magistrate, and we would find that in many cases that if someone sat down and talked to the person for 10 minutes, the matter could be resolved without the filing of papers that might take several hours in a more formalistic judicial proceeding like a magistrate's hearing, which is not different from an administrative law proceeding.

And with that kind of an intermediate step I think we'd give the citizen a chance to speak up and probably solve a lot of the problems. Then if it can't be solved—if there's some dispute—so be it. But I think that determination could be made in very short order.

Secretary SCHWEIKER. We'll take a good look at that; that's a constructive idea.

Senator SPECTER. Thank you, Mr. Chairman, thank you, Mr. Secretary.

Senator SCHMITT. Mr. Secretary, in this regard, are you familiar with your Department's disability determination unit?

Secretary SCHWEIKER. The one we were just talking about here?

MEDICAL REVIEWS FOR DISABILITY BENEFITS

Senator SCHMITT. Yes; in regard to this, the disability determination unit, which is the step, I think, prior to the administrative law judge, that is available. When we have cases brought to us, in our senatorial offices in New Mexico, we work with the disability determination.

Secretary SCHWEIKER. The State disability determination units do the medical reviews for us. In other words, when I said there was a medical review, that's who conducts the medical review.

Senator SCHMITT. But is that an opportunity to get the kind of direct or indirect face to face? If they're doing the review, why in the world couldn't that review at least include a 2-minute interview with the person they're reviewing?

Secretary SCHWEIKER. Well, they do a medical review, and, if needed, they would send the beneficiary to a private doctor for a medical opinion. So the person could get a private examination, but it wouldn't necessarily be face to face with an agency staff person.

That's the way it's done now. Now, we can do it any way you want.

Senator SCHMITT. Is the disability determination unit a part of HHS?

Secretary SCHWEIKER. That's a State function, but it ties into our function.

Senator SCHMITT. But isn't that where these kinds of cases should be weeded out? Why are they leaking through, if in fact these are?

I must admit that we are seeing a tendency to try to find all the horror cases we can find in order to publicize the adverse effects of change, but nevertheless they do occur, and we have to deal with individuals. My office does everyday.

Secretary SCHWEIKER. This disability determination service, in the case of this Virginia man, actually reversed a decision the same agency had made a year before. So the process was functioning. I think in this case it was functioning fairly.

One year they made one judgment, and after the disease had deteriorated, they made another judgment. To some extent, that is what their role is. Whether we can build up a face-to-face meeting into the process is something we can look into.

Senator SCHMITT. Well, I'm just suggesting that if there is already a review process it is time-consuming in itself.

Secretary SCHWEIKER. It has to be.

Senator SCHMITT. And I can't see why there can't be a portion of that devoted to face-to-face interviews. It can be very brief, just to make sure that there's nothing of an obvious nature that slipped through the cracks for some reason.

In my office, when we get an appeal or a question for a constituent who's been dropped off disability, we usually interview them face to face.

Secretary SCHWEIKER. We will look at the idea.

Senator SCHMITT. In that sense we provide a face to face. If there's an obvious case where the disability is real, well, then, we can provide that input, but not everybody will come to a senatorial or congressional office.

PHASEOUT OF PSRO AND HEALTH PLANNING

Mr. Secretary, we've been hearing for some time about administration proposals to make health care—the health care industry—more competitive. In fact, the proposal that Congress has yet to see uses one rationale for phasing out the PSRO program and the health planning program.

What is the status of this proposal and when do you think Congress will see it?

Secretary SCHWEIKER. The three parts to the proposal are before the President now awaiting a final decision and one part of it is coming up in the form of a prospective reimbursement section.

Senator SCHMITT. Should we have a chance to examine this within a few weeks?

Secretary SCHWEIKER. With the budget problem, the White House has decided that the budget crisis has to be resolved first before they get into this.

My guess is that probably it won't be forthcoming until after the budget situation is resolved. We have the three elements and we are going ahead with the fourth element.

Senator SCHMITT. Well, separating the budget crisis from the appropriations crisis, can we expect to have some insight into the competition proposals before we have to make a final decision on whether to agree to the proposals on PSRO and HSA programs?

Secretary SCHWEIKER. I'll make sure you get a copy of the options we have under consideration, but until the President signs off on that, I won't be authorized to present anything to the committee.

Senator SCHMITT. I understand, but, you know, our evaluation of the phaseout of those two programs has to be based in part on our perceptions of what is going to replace them.

Secretary SCHWEIKER. On PSRO's we are only curtailing the Federal subsidy, PSRO's can work in the private sectors. We will reimburse the PSRO's through medicare and medicaid. We'll pay for them; people don't seem to understand that.

They think just because the Federal Government is not paying directly for PSRO's, they can't function. We allow reimbursements once you utilize the PSRO. They can receive reimbursements if they bill us for the legitimate cost of medicare and medicaid. That point is lost. We were subsidizing them directly before. We say the Government shouldn't do that now.

But we'll reimburse providers that use the PSRO's, and so PSRO's can get money if they're effective. If the provider feels they're doing a service, they're supportable. That's an important point to think about, Senator.

Senator SCHMITT. So if in a local situation, in New Mexico, for example, where providers at least at this time are telling me that they have an effective PSRO, if they wish to continue to support that locally, then there are legitimate costs that can be reimbursed.

Secretary SCHWEIKER. Yes; and some are banding together and doing exactly that. Some of the areas are letting a PSRO unit handle a number of providers in the area and bill them, and then we can pay them. We're willing to pay that. That is exactly how we would like to work the system.

Senator SCHMITT. Could you provide for the record some details on what costs are considered reimbursable relative to PSRO's.

Secretary SCHWEIKER. Sure.

[The information follows:]

REIMBURSABLE PSRO COSTS

There are a number of ways some effective PSRO's could continue to receive indirect Federal support, as illustrated by the two examples below.

In the event legislation is passed eliminating PSRO and utilization review requirements, States will have the flexibility to establish medicaid utilization review systems more suitable to their particular needs. States may wish to use effective PSRO's as part of this system; approximately 50 percent Federal financial participation—FFP—would be provided for such quality assurance mechanisms.

Similarly, hospitals which are supportive of their local PSRO's may also wish to contract with those PSRO's to assist in fulfilling utilization review standards imposed by the Joint Commission on Accreditation of Hospitals. These costs are an element of a hospital's operating overhead and, as such, would be partially chargeable to medicare.

LIMITS ON COMPETITION IN HEALTH CARE

Senator SCHMITT. But aren't there limits on how competitive a health care system can be? I mean, we're really not dealing with a consumer situation that is comparable to the rest of the free enterprise system, as I've said probably too many times before.

The consumer of health care is a reluctant consumer. They want the best health care, not the cheapest necessarily and they are an unwilling recipient of it to begin with. So we have to be very careful philosophically, do we not, in how we structure a so-called competitive health care system.

Secretary SCHWEIKER. Let me give you two quick illustrations, Mr. Chairman, of what I'm talking about on competition. A House committee just held some hearings about the money that we were paying certain well-known national laboratories for their medical tests for medicaid. Basically they found out that the Federal Government was being billed 3 to 4 times what the private doctors and private patients were in the area.

We're being assessed in one case 5 times the rate at which the private sector unit was billing the private physician and the private patients. That is what I mean by the need for competition.

We have infrastructures that let the Federal Government get socked for 3 to 4 times what the going rate that everyone else is paying.

I had another case where a Congressman sent me a bill of his constituent for $26,000—17 days in the hospital. The lady complained because she wasn't paying the bill; we were. She was upset. She said she checked with other friends that had a similar operation, a similar length of stay of 17 days, and the average cost for her friends was $8,000. She got a bill for $26,000.

The hospital told her not to worry about it. She didn't have to pay that bill; the Government did. Well, she did worry about it, sent it to us, and we found out, in fact, we were overbilled $18,000. In this case, they said it was computer error, Mr. Chairman.

I've just got to believe there's an awful lot of that out there. And when hospital costs go up 19 percent, I think they need a little competition.

If we tell them that they have to provide a certain amount of services for a certain period of time, they won't be sending a $26,000 bill through the system.

The truth of the matter is, if that lady hadn't complained, we probably never would have spotted the bill. We are paying 40 percent of all hospital bills now. We can only review 2 or 3 percent on a statistical sampling basis. Therefore, except for her complaint, $26,000 would have gone right through the system because we don't have a competitive element in the system.

And when national laboratories that are well known get away with billing us 3 and 4 times what they bill private patients, that's a lack of competition. It's a monopoly situation. So that's what we mean about cleaning up those rather shoddy practices that we're paying the bill for. I don't question that they're rather widespread.

Senator SCHMITT. Mr. Secretary, I don't question it either, but I'm curious to have a little more specifics on how competition would solve the two problems that you put forward.

Can you be more specific? What would you do to prevent that?

PROSPECTIVE REIMBURSEMENT

Secretary SCHWEIKER. On the prospective reimbursement we would say, for example, that the pattern for treating people with these diseases averaged a certain amount of money. Then we would give that hospital a budget.

So the hospital would then have to live on that budget for the year, just like a business has to live on what it expects its gross receipts to be for the year. And they wouldn't be billing anybody for $26,000.

That hospital wouldn't pay more than $8,000 for that operation because we wouldn't be sending them funds for $26,000. They'd have to swallow the extra amount.

By the same token, in prospective reimbursement we would not let them charge us 400 percent what they are charging other people now.

Senator SCHMITT. How are you going to set the initial budget?

Secretary SCHWEIKER. Well, that is exactly what my task force is working on now. There are four or five different ways of doing it, and we are trying to decide on one that we feel is fair and one that the hospital community will accept. They're receptive, and we hope we can work with them on this.

But I think it takes the cheaters out of the system.

HEALTH PLANNING AND HEALTH INSURANCE

Senator SCHMITT. Is it your presumption that the abnormal rate of increase in hospital costs, even at a time of declining inflation, is the result of the abuses within medicare and medicaid?

Secretary SCHWEIKER. No; my presumption is what my chart said here; that insurance hides the real costs of what's happening. Nobody seems to get hurt by it. Out-of-pocket expenses to the patient only increased by $2 while the per diem bill went from $15 to $260.

Senator SCHMITT. I know what you're saying, Mr. Secretary, but it's because insurance hides the costs that they're getting away—and the Government cannot see the costs—with these kinds of price increases; right?

Secretary SCHWEIKER. We think that if we use a voucher system where health care providers are free to bid on that voucher and provide certain services, that the element of competition will come in. They'll provide the services for that dollar amount or they won't.

And we also feel that prospective reimbursement will put fiscal constraints——

Senator SCHMITT. So by prospective reimbursement you hope to get the hospital shopping and bargaining for the best fees. Or the physician, or what have you?

What about surgical fees, as an example of another area?

Secretary SCHWEIKER. Well, basically, doctor fees per se have not increased that far above the cost-of-living increase.

Doctor's fees, in general have not been rising more rapidly than other costs. Hospital fees are a different proposition. You certainly have to look at that like everything else.

But I want to be fair to the doctors, because their fees by and large have not gone up faster than inflation. It's just the hospital costs, some of which would have surgical fees in them.

So I make a distinction between somebody operating in a hospital and somebody working in his office.

Senator SCHMITT. Well, we're going to be very interested in these proposals. I think there also would be concern that hospitals in different geographic locations and even within the same States—possibly within the same town—would have inherently different costs for a variety of reasons: the age of the hospital, the nature of the management organization—you name it.

Secretary SCHWEIKER. We do recognize that. We would make some allowances for that. It's the difference between the $8,000 and the $26,000 bill that I get upset about.

Senator SCHMITT. Senator Specter.

OMB MEMORANDUM A-10

Senator SPECTER. Thank you, Mr. Chairman.

Secretary Schweiker, have you had occasion to see a recent memorandum from Mr. Stockman dated March 29, which purports to make some changes in the responses to be made by executive departments from providing plans for the use of appropriations that exceed the President's request?

Secretary SCHWEIKER. Yes; I did.

Senator SPECTER. You perhaps have the best or at least the most unique vantage point of anyone, having been on both sides of the table, most recently being in the Senate in the appropriations process on the subcommittee and now being the executive head in responsibilities that the Appropriations Committee has and the subcommittee has to make some sort of judgments or follow through the thinking process of the executive branch.

It's obviously necessary to have as much material as possible and to know the evolution of clients, and there is the tug and pull from the executive branch—at least from Mr. Stockman's perspective—to keep the aperture closed.

Would you care to comment on the most recent Stockman memorandum?

Secretary SCHWEIKER. What date is that?

Senator SPECTER. March 29, 1981, circular A-10, revised, transmittal memorandum No. 1. And it's section 4-D.: "In responding to specific questions, the program appropriations request, witnesses will refrain from providing plans for the uses of appropriations that exceed the President's request."

It's headed: "This transmittal memorandum amends paragraph 4–D of OMB circular No. A–10, revised, dated November 12, 1976."

4–D is changed to read: "Directed to heads of executive departments and staff."

Secretary SCHWEIKER. Yes; I have a copy of that. I guess my response is that I feel it is our responsibility as Cabinet officials to be responsive and candid to the committee. As a former Senator I feel that way.

I think where I would have to look at a particular issue or question closely would be where an opinion was asked that would have a budgetary impact. I obviously have some obligation to go back to OMB. It clears our testimony anyway. But lacking some major budgetary impact where I would have to go back to OMB, I have been, I think, very responsive and candid in replying, and I hope that my colleagues have too.

Senator SPECTER. Secretary Schweiker, how does this memorandum change prior policies?

Secretary SCHWEIKER. Well, my guess is that we're dealing here with off-the-cuff responses.

Prior policy dictated that before testimony of any Cabinet official was put forth to the committee or sent to the committee that it had to be cleared by OMB for its budgetary impact.

What hadn't been done before, as I understand it, was to deal with the situation the Q and A. So obviously if there's Q and A in certain areas and judgment has not been rendered by OMB, the Cabinet member is somewhat on his own at that point as to what his opinion or what his judgment is.

So it puts a further definition of what a Cabinet member's response can be on Q and A.

Senator SPECTER. It says: "Witnesses will refrain from providing plans for the use of appropriations that exceed the President's request."

Had it been permissible in the past for witnesses to provide plans that did exceed the President's request?

Secretary SCHWEIKER. Well, I think what they're getting at is—and I don't know what triggered this memorandum—but my guess would be that some people well may have given a personal opinion in terms of a policy that had budgetary impact, and that budgetary impact hadn't cleared OMB and hence the White House. It would be a personal opinion and not an official administrative one. This would be my guess.

Senator SCHMITT. If the Senator would yield, I think it's clearly been the occasional practice in the Appropriations Committee to ask witnesses, including Secretaries, if there was an $x million increase in a particular line item, if that could be used.

And generally the committee has expected an answer, without prejudice, I must say, from the witness. The same goes for asking the witnesses and particularly Secretaries to provide their budgetary requests to OMB.

Traditionally, those have been provided if requested. Whether Mr. Stockman is trying to change that policy or not, it may be incidental, because I certainly think the Congress would still expect answers to those relatively innocuous questions without hesitation.

I think the Secretary has said that he would expect to continue to be responsive and candid to the subcommittee and the committee's requests. I do not think we want to abuse that opportunity, but many times that is important information in order to fully understand how the budget was developed.

Senator SPECTER. Well, there were a great many people who testified before this and other committees who with all due respect do not have Secretary Schweiker's standing, background, or experience, who might be more influenced by this kind of a directive, which could well limit the ability of the committee to get pertinent information.

Senator SCHMITT. Well, believe me, Senator. If any witness feels intimidated by these memorandums and is unwilling to answer, there are other steps that the committee can take to insure that they do answer.

Senator SPECTER. That sounds pretty onerous, Mr. Chairman.

Senator SCHMITT. Well, that's been the tradition of the Appropriations Committee, and I fully expect it to be adhered to, notwithstanding Mr. Stockman's memorandums to the contrary.

Senator SPECTER. I haven't been around very long. Secretary Schweiker has had more experience, probably, than anybody in the room.

What is our recourse as a senatorial committee, Mr. Secretary? I prefer to ask you than the chairman.

Secretary SCHWEIKER. I think you should direct that question to David Stockman.

Senator SCHMITT. And we certainly would, if it ever became necessary to do so. I can sympathize, having been on the administrative side of Government, I can sympathize with the problem Mr. Stockman is trying to address.

But now on the congressional side, where certain information clearly is pertinent to our deliberations—whether the administration likes to make it available or not—I think we expect that the OMB in no way would stand in the way of witnesses providing candid answers to our questions.

Senator SPECTER. Well, I can see, on the submission of testimony, the rule—frankly I have a hard time seeing why the Secretary's testimony would be submitted to OMB. But those rules have been established, obviously, with the President's approval—express or implied. Even when the Secretary comes and testifies, the prepared testimony is submitted to OMB, and if you don't like what you get back, you can negotiate. That's what you do at times: You assert what you want and thrash that out between the Secretary and the Director of OMB, when the occasion warrants it.

But I wonder about a practice where this kind of a memorandum is promulgated from Mr. Stockman to the heads of executive departments—the Cabinet officers—really making this kind of a unilateral change in procedures.

Maybe it's not a very big deal—I don't know. But it seems to be.

Senator SCHMITT. It won't be a big deal unless the Secretaries and other witnesses follow it to the letter. Then it'll be a big deal. [Laughter.]

Senator SPECTER. Perhaps the chairman has a good idea, perhaps we ought to start all the hearings with a form of Miranda warning: You have a right not to remain silent. [Laughter.]

In subparagraph 4–D you will be provided with counsel if there's a contempt citation.

Senator SCHMITT. You do not have the right to remain silent.

Senator SPECTER. I yield to the chairman.

SUBCOMMITTEE RECESS

Senator SCHMITT. Mr. Secretary, this might be an appropriate point to break for lunch. I believe that you're scheduled to be with us again at 2 o'clock when we'll try to proceed through the remainder of our questions.

Secretary SCHWEIKER. Thank you, Mr. Chairman.

Senator SCHMITT. The hearing is recessed until the hour of 2 o'clock.

[Whereupon, at 12:25 p.m., Wednesday, April 14, the subcommittee was recessed, to reconvene at 2 p.m., this same day.]

(AFTERNOON SESSION, 2:10 P.M., WEDNESDAY, APRIL 14, 1982)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBCOMMITTEE PROCEDURE

Senator SCHMITT. Mr. Secretary, we'll come to order. I apologize for being a little late. We're trying to, by sheer weight of prayer, bring interest rates down. [Laughter.]

We got inflation down, and that was supposed to do it, but apparently it was not enough. So now we have to figure out some other way to do it.

Secretary SCHWEIKER. That's very important.

PUBLIC SERVICE HOSPITALS

Senator SCHMITT. In the current fiscal year, Mr. Secretary, Congress provides $146 million for transferring the eight public service hospitals to local and other sponsors. Is the Federal Government now free of all financial and other responsibility for hospitals and clinics?

Secretary SCHWEIKER. With the exception of the Hansen's Disease Center in Louisiana, the answer is, "Yes." This is the leprosarium.

Senator SCHMITT. That is the exception because of the transfer to Department of Defense; is that correct?

Secretary SCHWEIKER. We're going to keep funding it because of the nature of the disease, leprosy. It's a rather unique facility. There's no way to transfer it to the private sector.

Senator SCHMITT. And is there an estimated cost on that, sir?

Secretary SCHWEIKER. $17.9 million.

NHSC PERSONNEL CEILINGS

Senator SCHMITT. Mr. Secretary as you and I have discussed before, the committee is concerned about personnel ceilings which create instability in the assignment of National Health Service Corps professionals and cause instability in the rural areas they serve. I want to thank you personally for the efforts that you've made, not only in New Mexico but nationally, to try to provide some continuity and stability in service.

Could you summarize for our record the current situation with respect to the National Health Service Corps professionals that are serving in rural areas and with respect to their situation when their contracts are up.

[The information follows:]

HIRING AND PLACEMENT OF NHSC HEALTH PROFESSIONALS IN RURAL AREAS

Within the authorized fiscal year 1982 field strength of 2,115 health professionals, the National Health Service Corps will be able to renew the contracts of 332 carefully selected health providers, and to employ 137 volunteer health professionals for shortage area practice. Of 1982 available scholarship-obligated health professionals identified to date for non-Federal, private practice option, assignments, 66 percent have been matched to rural practices. The program will continue to place heavy emphasis upon rural communities during the remainder of the 1982 placement cycle.

FREEZE ON HIRING

Secretary SCHWEIKER. Before I get into the figures, let me say that part of the problem, not the whole problem, but part of the problem was that we had a freeze on hiring personnel in the Department. This freeze made the problem in this area much worse than it was as of last time we spoke, which might have been 3 or 4 weeks ago. I just lifted that freeze for certain high-priority areas. The Indian Health Service and this area of the Public Health Service were some of them. I think that most of the problems that you and I have discussed have pretty well been resolved. The other aspects of it, I think, have also pretty well been resolved.

The field strength is just about where we hoped it would be. We aren't forcing anybody out, as was the concern earlier, so I think both problems have been resolved.

We have increased the private practice option, and that has been quite successful so far. That has helped solve what people were concerned about. By the same token, we feel that with the private practice option, we have the best chance of keeping people in rural areas beyond their tour of duty. So we're very interested in pushing that, and we have a goal this year of 712. We believe there is a good chance that we can reach that goal. So right now things look pretty good.

HEALTH PROFESSIONS STUDENT LOAN DEFAULTS

Senator SCHMITT. In the health professions student loan area, Mr. Secretary, a recent study by your Inspector General found that more than 6,000 physicians have failed to repay more than $5.2 million in low-interest Federal loans under the health professions student loan program. Despite being delinquent in Federal loans, 401 of the doctors have received more than $10 million in medicare-medicaid payments over the last 2 years. Furthermore, approximately 80 of these physicians are currently employed by your Department.

What steps will the administration take to collect these delinquent loans?

Secretary SCHWEIKER. I've ordered a crackdown by the Inspector General, and I have specifically notified each of the delinquent persons in my Department about the situation. It's interesting that since our Department released the report, a substantial number have paid up. We've corrected part of this problem just by having some publicity about it. I intend to follow up personally with the others in my Department who are delinquent, because I think it's abhorrent. We are also getting in touch with the various institutions around the country. Unfortunately, I can control my own Department and will attempt to do exactly that. However, to get out in the other areas, we're going to request some law changes to give us more authority to deal with this problem. We're putting all the academic institutions on notice that have these delinquencies that we want to see these repayments made a high priority.

We're also looking into how to deal with the people who get medicare and medicaid payments from our office. So there are three ways we're attacking it. I concur wholeheartedly with your point and have initiated the probe. I assure you we are going to get it cleaned up one way or another, but we probably do need some stronger provisions to deal with the problem when it involves those outside the Department. For our own part, we should get repayment from the Department employees.

Senator SCHMITT. When would you expect that we might see some suggestions from the administration on any law changes that might be required.

Secretary SCHWEIKER. I should probably just explain one more thing. We have some authority to move now, in terms of the institutions involved, and we are going to be asking for more authority in terms of the individuals involved. That will be forthcoming. Well, here's an example. We're going to ask for the IRS to release to HHS the locations of delinquent borrowers in the loan program. We're asking schools to transfer the delinquent loans to the Federal Government for collection. We're going to ask for an increase in interest charges for the delinquent payments to the maximum allowable under State laws. We're going to ask the Health Care Financing Administration to reduce medicare and medicaid payments to delinquent loan recipients to offset the dollars owed to the Federal Government. These proposals are presently at OMB awaiting clearance.

Senator SCHMITT. Mr. Secretary, do you feel that you have the authority to withhold reimbursements to physicians that are delinquent on health profession loans, medicare-medicaid reimbursements?

Secretary SCHWEIKER. We don't think we do; no. That's the part we need help for. We don't see a legal basis for doing this. I just don't see any part of the law that gives us that authority to do it, because they're totally different laws. If there are any legal opinions here on the staff that can give us any basis for it, believe me, we will be delighted to pursue it, because I think this is ridiculous.

Senator SCHMITT. Please keep us informed. The subcommittee will be almost unanimous in support of you.

Secretary SCHWEIKER. There was a very prominent case that was mentioned recently in a paper here. Somebody who was getting a lot of money from us. Since that publication, we've gotten some back payments already. So publicity does have a very beneficial effect.

Senator SCHMITT. Well, I hope it does. I've seen a recent example of a congressional candidate who published his net worth statement which included a $1,200 delinquent student loan. Needless to say, the publicity that that received, I think, helped publicize the problem we have with student loans. His net worth was about $250,000 .

Secretary SCHWEIKER. But I assure you of my 100-percent cooperation, because I ordered a crackdown in my Department when I first learned about it.

Senator SCHMITT. It was just the question of whether it was listed as an asset or a liability, and I don't remember.

Secretary SCHWEIKER. One of the interesting things is we can't even withhold funds from the salaries of our own employees who are in default. We don't even have the authority to do that. We do have the authority to call it to the supervisor's attention, and we can talk to them. That's exactly what we're doing, but we just haven't been given enough statutory authority to follow it up.

Senator SCHMITT. Well, I just think we ought to consider it. The one thing that I have traditionally been concerned about is trying to have loans collected through the IRS.

Secretary SCHWEIKER. I'm just talking about deducting from our payroll.

Senator SCHMITT. I understand. I think on an agency-by-agency basis, that's certainly well worth considering, but to turn the IRS into a small claims court——

Secretary SCHWEIKER. We're not asking for that.

Senator SCHMITT. I know, but some people do. And I just want to make it clear that that is probably not an option that would be good, because we're dependent on a voluntary tax system, and as soon as you start trying to withhold those kind of things through the tax system, you're liable to undermine the voluntary nature of that system. There are other options, and you have described some, and I hope that we can consider them.

PARENTAL NOTIFICATION FOR FAMILY PLANNING

Mr. Secretary, last year Congress passed an amendment that directs recipients of family planning grants to "encourage" family participation in these activities "to the extent practicable." The accompanying report also states that the conferees' view is that "family involvement is not mandated." Now, however, the Department has apparently published a proposed rule that would require federally supported family planning projects to notify the parents of "unemanicipated minors," who are provided prescription birth control devices and drugs.

What is your response to the criticism of that, that these regulations go beyond the intent of Congress, and that there's a strong likelihood that the parental consent requirement will discourage many teenagers from seeking counseling in the first place, increasing the incidence of teenage pregnancy?

Secretary SCHWEIKER. First, Mr. Chairman, it's important that we aren't requiring parental consent. You probably said that inadvertently, but we're not requiring parental consent.

Senator SCHMITT. But you require notification?

Secretary SCHWEIKER. Yes; you just mentioned consent. You said consent.

Senator SCHMITT. Yes, of course, I stand corrected.

Secretary SCHWEIKER. In fact, we also aren't requiring prior notification. So all we are asking is that after the fact, after the teenager has gotten a birth control device, that the parents be notified. We do this for two reasons. First of all, we believe that the movement has been the other way, that we, in essence, have kept it a secret from the parent and have interposed the Government to deal with a teenage child in a way that we feel violates the parent-child relationship. No. 2, we also feel there's some serious health risks that a parent has a right to be informed about if we help in funding that particular prescription device or prescription drug. In the cases of the IUD and the pill, there certainly are risks that we feel parents have a right to know that the Government is subjecting their children to. We do not feel, since we aren't requiring consent and since we aren't even requiring prior notification, that it goes beyond the law.

I realize there are honest differences on this. Senator Hatch and Senator Denton, who participated in that conference, feel that the regulations do interpret the law accurately. So there are some honest differences of opinion in this area.

There's a study from Baltimore that I think is interesting. In the low-income neighborhoods of Baltimore, a study was done that showed that where a parent and a child talked and discussed the matter among themselves, that 52 percent said, basically, that they would use contraceptives. Where a parent and a child didn't talk about it, where there was isolation, a barrier between the parent and child, only 23 percent of the teenagers used contraceptives.

So my point is that twice as many teenagers use contraceptives where the parent and child communicate with each other as when they don't. I think that's a very, very significant point. The study was conducted by Dr. Furstenberg, entitled "Unplanned Parenthood: A Social Consequence of Teenaged Childbearing by 400 Pregnant Teenagers in Baltimore."

So we really feel it will help the situation to have people openly discuss it, instead of having the Federal Government hide it in the closet.

Senator SCHMITT. But the conferees' view was that family involvement is not mandated.

Secretary SCHWEIKER. Well, it said "encourage family partisipation." We are encouraging family participation by notification after the fact. They still may not participate. The parent or child may still do their own thing. There's no compulsion, in terms of consent. The parent and child can go their own way. And the parent has no right to tell the child, under our proposal, that the child can't have that device or that pill.

Senator SCHMITT. It is, I think, semantics, whether or not a required, after-the-fact notification is not involvement by the family. I think notification is involvement.

Secretary SCHWEIKER. I would admit that there is a close question here involved in just how that's interpreted. I think it's also important though to know that some of our clinics notify parents now—20 percent do it now for 13-year-old children and under. And I think if it's 15 or under, 10 percent notify parents. I just honestly feel when we're giving birth-control devices to 11-, 12-, and 13-year-old kids, that we do have some responsibility. If 20 percent of the clinics do it now for the 13-year-olds, and 10 percent do it now for the older kids, and nothing happens, the sky doesn't fall in, they haven't stopped coming and they're utilizing it, I really think that everybody can do it. I can't understand if 20 percent can do it successfully, why we can't get everybody to do it successfully.

Senator SCHMITT. I think it's because, Mr. Secretary, there's a difference of opinion on what the effect on young people's, teenagers' attitudes will be, if they know their parents are going to be notified after the fact. We get differing opinions, just as you have, and I hope that you'll provide for our record a summary of studies such as the Baltimore study, if you would, for members of the committee to examine, and hope that we can see just exactly what the real effect may be of this kind of a rule.

Also there is some concern that it's discriminatory. It deals with the female and does not include the male.

Secretary SCHWEIKER. It's only discriminatory because we're dealing with prescription devices.

Senator SCHMITT. Because of biology, it's discriminatory.

STUDIES ON THE EFFECT OF PARENTAL NOTIFICATION

Secretary SCHWEIKER. I'm sure that sometime that we'll come up with a pill for men, and then it won't be discriminatory. It'll be a prescription drug too. They're working on a pill right now for men, as a matter of fact. So at some time, they'll make it even. We'll treat everybody equally. But now one group gets a prescription drug and a device and the other group doesn't get a prescription drug or device. I might say that the Alan Gutmacher Institute made a survey and one of the results which hasn't been cited too often, except by us, is that 96 percent of the teenagers said, if parents were informed, they would continue to use contraceptives, if they continued to engage in sex. So at the most, using the figures of people who support planned parenthood, you're only talking about 4 percent who might not choose to use contraceptives.

In a sample of that size, 3 or 4 percent is the normal sampling error. So even the Gutmacher Institute admits that the kids will continue to use contraceptives if the parents know about it. So I just don't believe, honestly, that kids will not use family planning services, but we're openminded. We're going to see how it works, and we're willing to listen.

Senator SCHMITT. I hope that you will provide us with a selection, an objective selection of those reports. It sounds like all the ones you've quoted so far are supportive and maybe that's all the information that will come about.

Can we expect to get that for our records.

Secretary SCHWEIKER. Yes.

[The information follows:]

PARENTAL NOTIFICATION REPORTS

The following reports are being provided to the commmittee for its files: (1) "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," by Aida Torres, Jacqueline Darroch Forrest, and Susan Eisman, in "Family Planning Perspectives," vol. 12, No. 6, November/December, 1980, 284-292; (2) Excerpts from Frank Furstenberg's book, "Unplanned Parenthood: The Social Consequences of Teenage Childbearing," The Free Press, 1976; (3) Excerpts from a chapter on "The Family's Role in Adolescent Sexual Behavior," by Greer Litton Fox, in Theodora Oom's book, "Teenage Pregnancy in a Family Context," Temple University Press, 1981, which reviews research on the relationship between parental communication and child's contraceptive practice. We are continuously looking for new studies which would provide further insight in this area. As new ones are found, we would be glad to provide copies to the committee.

Summary of the Guttmacher Institute study.—In late 1979 and early 1980, Alan Guttmacher Institute clinic staff surveyed teens under 18 years of age who were receiving prescription contraceptive methods from 53 family planning clinics. Each of the approximately 1,200 unmarried minors who were surveyed indicated whether or not her parents knew about her clinic visit and, if parents did not know, what she would have done if their notification had been required by the clinic. A total of 54 percent of the girls reported that the parents knew of the attendance; 5 percent more were not sure if parents knew or not; 18 percent said the parents did not know, but telling parents would not preclude clinic attendance. The remaining 23 percent said their parents did not know and that notifying parents would cause them not to come to the clinic. Of the 23 percent who would not come if parental notification were required by clinics, the following breakdown exists: Have sex but use nonprescription methods—15 percent; have sex but use no method—4 percent; not have sex—2 percent; don't know—2 percent. (Source: "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," by Aida Torres, Jacqueline Darroch Forrest, and Susan Eisman, in "Family Planning Perspectives," vol. 12, No. 6, November/December 1980, 284-292.)

Summary of the Baltimore study.—Frank Furstenberg found that communication between parents and children makes it more likely that sexually active teenagers will use contraceptives. He found in families where birth control was discussed, 52 percent of the daughters had used contraception compared to 23 percent when birth control had never been discussed. The study covered 404 low-income pregnant teenagers and their mothers in Baltimore—40 percent of the families were female-headed; 90 percent of the participants were black. (Source: Frank F. Furstenberg, Jr., "Unplanned Parenthood: The Social Consequences of Teenage Childbearing" (New York: Free Press, 1976).)

USE OF FUNDS FOR NIOSH TRANSFER

Senator SCHMITT. Last year the President requested that Congress approve the transfer of headquarters employees at the National Institute of Occupational Safety and Health from Rockville, Md., to Atlanta, Ga., and Cincinnati, Ohio. Congress, however, included language in the continuing resolution which prohibited the use of funds on the bill for such a move, my recommendations to the contrary notwithstanding.

What is the status of the proposal to move NIOSH headquarters out of the Washington, D.C. area?

Secretary SCHWEIKER. I made the decision as Secretary to move the headquarters—on June 22, 1981. Let me say why I made my decision.

I made my decision because Dr. Foege, who is head of the Centers for Disease Control, recommended that we put the Institute, which comes under his control, physically in his area so that he can control it.

And it was Dr. Foege, a career civil servant appointed by Joe Califano to his job and I elected to keep him on in this job—it was Dr. Foege's recommendation that he could best manage this NIOSH divison of CDC in Atlanta. So I took the recommendation of a career civil servant, appointed by Mr. Califano, and put it into action on June 22.

Technically on that date, the headquarters of NIOSH moved to Atlanta. On December 15, the third continuing resolution passed that prohibited me from using any money to transfer employees from Rockville to that location, and we've honored and respected that.

Senator SCHMITT. You, I presume, are advocating that that restriction be lifted.

Secretary SCHWEIKER. I certainly am, Mr. Chairman. It would be different if this was some kind of a partisan issue, or even something the Reagan administration decided to do on its own.

It was done because Dr. Foege felt that he could manage NIOSH best there. He thought he could consolidate some of the activities and save some money because he could use the administrative support staff of the CDC down in Atlanta and also because most of the work for NIOSH is not even done in Washington. It's done out in West Virginia or it's done in Cincinnati, Ohio.

So to have the headquarters operations in Atlanta and then part of the operations in Washington, a research operation in West Virginia, and another research operation in Cincinnati doesn't make any sense at all managerially and logistically.

Now I can understand that Congressmen and Senators don't like to see jobs leave their areas. By the same token, we were only talking initially about some 77 people, because 80 percent of the people don't even live in the Washington area. They live in either Cincinnati, Morgantown, W. Va., or Atlanta.

And I'm puzzled about all the controversy generated, when it's a very logical, rational decision and something that Dr. Foege would still very much like to do.

Senator SCHMITT. Well, Mr. Secretary, I agree with your analysis. We will see what happens this year. Not all members of the committee were involved in the vote, and it may be possible——

Secretary SCHWEIKER. In fact, in terms of research and working with the health departments of various States, the CDC center is an ideal setting for it. We work with health officers from other areas because of our immunization and other programs, so it's logical to work for them on occupational safety from CDC.

CDC has an ongoing relationship with all the State health departments from Atlanta. We also have a base for research there, and we also have an administrative base there. So I thought Dr. Foege's request was very logical and frankly, it wasn't political. So I appreciate that.

Senator SCHMITT. We will see what we can do. Mr. Secretary——

Secretary SCHWEIKER. I might say we hope to save about $1.5 million a year because of consolidation of administrative support services.

RISK REDUCTION AND HEALTH EDUCATION FUNDING

Senator Schmitt. Risk reduction and health education funds were folded into the preventive health and health services block grant, which is in its first year of operation. Their fiscal year 1983 budget requests $1.3 million for risk reduction and health education activities separate from these block-grant funds.

What is the purpose of the separate funding?

Secretary Schweiker. This is in health education, you're saying?

Senator Schmitt. It's in CDC, in the preventive health and health services block grant—risk reduction and health education funds.

Secretary Schweiker. Well, the only risk reduction activities that come into mind offhand are those in the block grant, but you're saying that beyond the block granting——

Senator Schmitt. It's our interpretation of the budget that you have $1.349 million in risk reduction and health education under preventive health services. These kinds of activities can be undertaken by the State under the preventive health and health services——

Secretary Schweiker. Oh, I understand. What happened, Mr. Chairman, was OMB had knocked it out of my 1982 budget. This year I appealed it and got it reinstated. So it was money that got knocked out in 1982 and I asked to have it reinstated in 1983.

But I was disappointed that we didn't have it in 1982.

Senator Schmitt. Is this to support Federal involvement in preventive health or in risk reduction and health education activities that complement State activities that can be undertaken under the block grants?

Secretary Schweiker. That's right. It's to work in the health education and risk reduction areas. We do need expertise to support the States in this area. It's a rather modest request, and basically it's to put a prevention strategy in effect for the States.

Senator Schmitt. Again, I guess it's not clear to me yet if the States will be undertaking comparable activities, is that correct, in making requests for support and assistance to you?

PROVISION OF TECHNICAL ASSISTANCE TO STATES

Secretary Schweiker. No; this is to provide technical assistance staff at the Federal level to help State programs, so that the States can utilize and call upon our technical expertise in this area.

As a followup on the question you asked me earlier this morning, about what bridge do we provide to the States to make sure that some technical information flows back and forth, we feel that prevention is a high enough priority that we ought to have a staff to provide that kind of technical followup. Just as it's important to immunization, we also feel it's important in health education and risk reduction because there are so many dollars to be gained by doing this.

Senator Schmitt. Well, a typical professional in your department being paid out of these funds would be a point of contact for his or her counterparts in the States?

Secretary Schweiker. Yes.

Senator SCHMITT. And could react to requests of information from other portions of the Department that might be related to risk reduction and health education?

Secretary SCHWEIKER. That's correct.

Senator SCHMITT. Acting in a sense as an ombudsman.

Secretary SCHWEIKER. This relates to the point you were making this morning, that is, that we are consolidating fiscal management and administrative management of block grants under the Assistant Secretary for Health.

By the same token we wanted to have some availability for technical expertise available when it was needed. We feel the prevention strategy is such a high priority that we ought to keep an ongoing presence here.

Now that Federal presence is still substantially less than it was in 1981, so it isn't that we're asking for $5.5 million as we had in 1981.

For 1982 these programs got blanked out; we're just asking to restore $1.3 million that was cut from the 1982 budget.

Senator SCHMITT. Mr. Secretary, there's been quite a bit of publicity recently.

PREVENTION SPENDING

Secretary SCHWEIKER. You know, Mr. Chairman, if I may give you one further answer, this morning Senator Inouye asked about prevention spending. I think there's a great misconception in looking at the Office of Health Prevention where we're only spending $2 million and the conference where spending is only another $2 million.

We have a whole booklet here on the money that is spent in prevention. Just briefly summarizing it, in 1982, CDC directly attributed $208 million to their prevention program; the Assistant Secretary for Health was $83 million; FDA was $283 million; HSA was $80 million; NIH was $571 million; and ADAMHA was $6.6 million.

So my figure wasn't too far off. We estimated just those five public health agencies were spending $1.234 billion on prevention. To look at an office and say you're only spending $2 million on prevention is not correct.

Senator Inouye had a misperception. It is easy to be misled because that office is just a catalytic agent where we determine the strategy to use, direct advertising operations, provide leadership, and interface with symposiums and seminars.

But the real work is done in these public health service agencies and we're putting $1.2 billion there.

Senator SCHMITT. Would it be safe to add that that does not include the direct benefits from basic research that lead to better prevention techniques?

Secretary SCHWEIKER. That's correct. This is just money that we're investing without attempting to figure what the return is.

Senator SCHMITT. This is the implementation of prevention rather than the research that would lead to better prevention.

Secretary SCHWEIKER. For example, CDC with their program in diabetes shows a tremendous dollar return in cost effectiveness that is not included in those figures. This is our out-of-pocket investment in prevention without an attempt to tabulate our return.

TREATMENT FOR SYMPTOMS OF GENITAL HERPES

Senator SCHMITT. Mr. Secretary, genital herpes has received a lot of recent publicity. In your professional judgment or those in your Department, how serious a problem is herpes in our society?

Secretary SCHWEIKER. It is a serious problem, Mr. Chairman, and I was delighted that we made a small but very significant step. Just recently the FDA announced that they have approved a new drug that while it will not cure genital herpes—and I think it's important to say it will not cure it—the drug will greatly relieve the stress, the pain, and the symptoms. It will make life a lot easier for the day-to-day living with this disease.

I am delighted that we've had this breakthrough that was released a few weeks ago and that acyclovir will be available for victims of herpes disease to use. We're also doing some research on a cure. Because the disease problem primarily is one of symptoms, this will go a long way toward relieving a lot of people, even though we haven't cured herpes.

REPORTING AND MONITORING OF HERPES

Senator SCHMITT. Do you believe it will help because of the existence of the drug now that you'll be able to get better monitoring of the disease itself—people will be more willing to come forward and identify the disease?

Secretary SCHWEIKER. Yes; we now have 10 training and prevention clinics for sexually transmitted diseases. We have put diagnosing and counseling for herpes patients right at the top of our priority list.

Up to this point, to be honest with you, there wasn't much we could do, except hold their hand and commiserate with them and say, it's a bad disease.

But now we can relieve 50 to 75 percent of the symptoms. It's a significant relief to the person who is distressed by some of the pain and some of the inconvenience and some of the trauma of the disease. So this really is a big step.

We also have the VD hotline operating, and 15 percent of the calls we get now do request information on herpes. So we are beginning to make a dent, but it was somewhat out of control. It's just beginning to get back in control.

UTILIZATION OF VD HOTLINE

Senator SCHMITT. What is the trend in the utilization of the hotline? Is it up, increasing rapidly as the population is increasing?

Secretary SCHWEIKER. I don't know without checking.

Senator SCHMITT. I don't mean just for herpes, but I mean generally.

Secretary SCHWEIKER. We did get 90,000 calls last year. I'd have to find out, though, whether it's up or down. But I think you're right that once we get the publicity out that we have a semicure—and I use that word "semicure" very carefully—people will come forward a lot more readily and we can deal with them. Before we did not have that much hope that they would come forward.

We do allocate some money—some $3.3 million—for further research for vaccines and treatment. We do have some hope that this will lead to a cure, because I think this is a very significant breakthrough.

[The information follows:]

CALLS TO VD HOTLINE

The VD national hotline received 15,960 calls concerning genital herpes during their fiscal year 1981. Almost one-fifth—19.6 percent—of all calls processed in 1981 dealt with herpes, more than for any other specific disease entity. Herpes calls for the first 5 months of fiscal year 1982 are running 50.2 percent above last year's monthly average. If herpes calls continue at the present rate, 23,976 calls will be recieved; more than one-fourth—27.4 percent—of all calls.

Overall call volume to the VD national hotline has already increased. The 1981 total of 107,724 calls—including off-hour calls—was 22.5 percent higher than the figure for fiscal year 1980. The average monthly call volume for the first 5 months of fiscal year 1982 is 8.6 percent above last year's average. This projects to a total call volume of 117,084 calls for fiscal year 1982.

NIH REDUCTION IN RESEARCH GRANTS

Senator SCHMITT. Mr. Secretary, the NIH budget abandons the concept of stability of new research grants by decreasing the number of grants from 4,741 to 4,100. You've also proposed to put a 90-percent cap on indirect costs associated with research, reduce the average costs of noncompeting continuation grants by 3 to 4 percent, and reduce training allowances to slightly below the fiscal 1982 level.

Have you been able to evaluate the ability of grant recipients to continue to produce good science and good researchers through the training program under these revised guidelines?

Secretary SCHWEIKER. First of all, let me say that again OMB had proposed a rather heavy cut in NIH that would put them below their actual funding level for the past year.

I appealed that successfully and so, while $100 million wasn't much of a factor, it was one of the few discretionary programs that increased in my Department. Discretionary programs have had a rough time with 95 percent of the Department's budget being entitlements. We did get a $100 million plus add-on.

INDIRECT COSTS OF RESEARCH

The problem in this area, though, is that back in 1966 the indirect costs for these research grants amounted to 15 percent. In 1975 it was 25 percent. Now they are up to 30 percent. This is a tremendous escalation that has nothing to do with inflation because this is a pro rata share of the cost that is going from 15 to 30 percent.

I think we must have some constraint put on here, just as with health care costs, and say, how much indirect cost can you tolerate?

I met with the heads of some of our largest academic research institutions just last week. This proposal is a rough way to go about it. If there are some other suggestions about how to do it, we're open to them.

But you know, back in 1966 we put a limit of 15 percent on indirect costs. We said that was it. So then we took the cap off; now it's mushroomed to 30 percent.

My point is, we've got to get some kind of fiscal restraint in the picture. This cap idea—I shouldn't say cap, but the 10-percent limitation may not be the best way in the world to deal with it. We're very open. If the committee has some other ways of slowing down that growth rate since the limit was removed, we're going to do it. But when it's getting to be a third of the whole grant, you begin to devour the principal, and that's what we're concerned about.

If the committee has some other ways of doing it, we're open.

Senator SCHMITT. Did the researchers give you any insight as to why the jump had occurred?

Secretary SCHWEIKER. Well, the only thing that they really pointed to that I can recall was energy costs. But, by the same token, I can't believe that energy costs amounted to a doubling of 15 to 30 percent.

I would have to admit that energy costs have gone up—although this year they've come down a little bit. My point is that this is a pro rata share, this is not an absolute dollar share.

If it's absolute dollars, I would agree that inflation is now eating up 30 percent of the grant. I don't hear too much from the researchers on this area, but I certainly have heard from the university officials.

Senator SCHMITT. Have they come up with any ideas?

CONSTRAINING INDIRECT COSTS OF RESEARCH

Secretary SCHWEIKER. Well, I asked them that very question and the answer is, "No." We are looking at one option and I'd be glad to have the committee's input on this, I'm not sure this is the answer either. One of the things that the NIH advised me that the director was looking at is the total package concept whereby we say, "Here is $300 million to do specific work. You spend it the way you want, to accomplish these objectives. And you divide the costs. We're giving you $300 million. You split it up one way or the other." Now we're forced to make very difficult decisions because we automatically say, "Add on your costs. You tell us the percent and we'll put it on." And there's no constraint, just like health care costs.

A total package concept would put on a constraint. People have to decide just where their costs are going. I don't know that that's the best answer either, Mr. Chairman. You've done a lot of work in this area. If you have some ideas, we'll be glad to hear them, because we don't want to put a straitjacket on universities. I realize they have some very tough problems now too.

I told them that we're not unmindful of their problems.

Senator SCHMITT. Do you find——

Secretary SCHWEIKER. If there's another formula for indirect costs, we'd certainly be willing to consider it.

Senator SCHMITT. Of course, indirect costs or overhead costs have always been a tough one to handle. There is a tendency of any institution, whether it's Federal or private, to try to carry as many institutional costs as they can on the backs of the research grants. I went through that even within the Federal Government and the U.S. Geological Survey many years ago where our indirect cost overhead had reached, I think by the time I left, 35 percent carrying the rest of the administrative burden of the institution. And I don't know what the answer is going to be, but I agree with you that there has to be an answer.

Secretary SCHWEIKER. We need something, Mr. Chairman. This idea we've presented may not be the world's best, and I would acknowledge that.

PRIVATE SECTOR CONTRIBUTION TO RESEARCH

Senator SCHMITT. Have you seen or is there any indication that the private sector may be contributing more now to research costs and indirect costs of major institutions in the health research area?

Secretary SCHWEIKER. Are you asking the question in terms of indirect costs?

Senator SCHMITT. Just generally, you know. The research institutions have been under tremendous financial constraints, and the private sector has only recently started to recognize that trained people may be as much of a resource as anything else that they need in order to operate. So there is, I think, an increasing influx of private money, not nearly enough from industry, but still it's starting again.

Secretary SCHWEIKER. We don't know those figures, but we'll get them. My estimate is that there's not too much change in this area, but we'll find out.

[The information follows:]

NON-FEDERAL SUPPORT FOR RESEARCH

The Department does not have access to detailed information on sources of amounts of funds made available to the universities and research institutions through the private sector. We estimate, however, that approximately $500 million was provided by non-Federal sources in research support to the universities and research institutions in 1981.

FEDERAL REGULATIONS' EFFECT ON INDIRECT COSTS

Senator SCHMITT. Have you considered any kind of a match?

Secretary SCHWEIKER. Well, we did that in the bill that passed the Congress. We gave an incentive in the bill last year to the industry to spend a certain amount over their previous research budget so that they could get tax credits.

Senator SCHMITT. But what I'm thinking is maybe you might consider for the indirect cost area, you might consider providing matching funds so that the university can leverage private contributions.

Secretary SCHWEIKER. I think that's a fair proposal. We should be looking at something like that as a way of getting more leverage out of our research dollars. I certainly would be willing to consider that.

Senator SCHMITT. Do you think that Federal regulations have contributed to this rise in indirect costs?

Secretary SCHWEIKER. Well, undoubtedly Federal regulations have some bearing. I honestly can't believe that they've raised indirect costs from 15 to 30 percent. We are also in the process, through the Director's Advisory Committee at NIH, of looking at what we might do to lessen that burden. But I wouldn't expect it would be a dramatic change.

Senator SCHMITT. Of course, many of the research grants go to hospital research institutions, do they not?

Secretary SCHWEIKER. Well, university affiliated hospital research; yes.

Senator SCHMITT. There I think the evidence has become quite strong that the cost of Federal, State, and local regulations on hospitals have exceeded one-third of their total costs. I think in New York State it's up close to 40 percent of the cost of running a hospital is the cost of administering various levels of regulatory activity.

Secretary SCHWEIKER. I have a task force on deregulation for hospitals. In fact, I'm working on this subject very intensely right now. This will have some bearing on your teaching hospitals, which is the area where regulations and indirect costs overlap. So to some extent, we are working on the regulation problem through the general subject of hospitals. But because teaching hospitals will be included, we hope maybe deregulation will relieve some of the burden. Just what the percentage of that might be, I don't know.

Senator SCHMITT. I think you might find for teaching hospitals and clinical research hospital environments, it may be quite large. And in that same period of time, we've seen the largest increase not just of Federal but of State and local regulations also.

Secretary SCHWEIKER. Well, we're certainly looking at that.

FUNDING A MINIMUM NUMBER OF GRANTS

Senator SCHMITT. Do you feel, Mr. Secretary, that we can ever get back to where we thought originally was a good minimum number of grants that we ought to be funding, namely 5,000? It seems like that was only last year.

Secretary SCHWEIKER. Well, all I have said is that, in the budget situation, I averted catastrophes. My job is averting catastrophes. A lot of my discretionary programs, as you well know, were cut 20 and 25 percent. I considered it a signal victory and a day for celebration when we didn't cut NIH, not 25 percent or even 10 or 5 percent. NIH has had increases. I have a couple of budget battle scars for it, and I take some pride in that.

I think if we can get the $100 billion plus deficit under control and get inflation rates down, my guess is we can get stable growth in the research area which I want to see. But short of that, it's all I can do to keep my head above water to make sure NIH hasn't gotten a cutback, which is not as good as the former growth pattern.

Senator SCHMITT. You're to be congratulated for that effort and we'll try to award you a Purple Heart here before very long, but my concern here is that you have to make those kind of battles to the degree that you do in an area that clearly is providing for reduced health care costs in the future. Understanding what basic science and technology and medical research does for the future seems to be notoriously lacking at the levels of budgetary decisionmaking that you have to deal with.

Secretary SCHWEIKER. One of the very things, the reasons we can have this indirect cost proposal is so we can add another 400 grants. So on the one hand we get criticized for cutting indirect costs. On the other hand, that would give us the stability of research grants, giving up to 400 more awards. We're trying to achieve a balance.

Now, maybe that's right or wrong, but that was the reason we decided on the indirect cost cuts so that we could get more grants and have more stability in the number of grants.

NIH CR BUDGET

Senator SCHMITT. Mr. Secretary, what funding base did you use to develop the fiscal year 1983 budget, the September 1981 budget level of $3.31 billion or the $3.6 billion level provided under the continuing resolution?

Secretary SCHWEIKER. Are you talking about NIH now?

Senator SCHMITT. Yes; for NIH. I'm sorry.

Secretary SCHWEIKER. We used the CR level of $3.6 billion. Now, in that $3.6 billion CR level base we gained $108 million. If you use another base, we probably did better than that, but we used the CR base of $3.6 billion.

Senator SCHMITT. Well, have the difficulties surrounding the development or the passing of the continuing resolution caused any problem in the continuation of grants?

Secretary SCHWEIKER. We gave special priority to NIH funding, Mr. Chairman, because when the first and second continuing resolutions were first passed, we put some limits on how much we could spend under them. But I made an exception for NIH because of their special situation. We couldn't cut off the scientific community and expect them to continue to conduct meaningful research under our grants, so we made a special exception in their case. So the answer would be there were no problems with NIH grants to my knowledge. Not everybody got treated so well.

Senator SCHMITT. In spite of the fact that the September budget request by the President was $3.31 billion, your Department assumed that you would be working at a $3.6 billion level so that there was no discontinuity in terms of grant funding.

CONTINUING GRANTS REFUNDED

Secretary SCHWEIKER. We kept every continuing grant funded without any interruption. The only adjusting we did was in new grants. That was just a matter of timing. In other words, we kept funding continuation grants so that they had no interruption. What we did do was phase in the new grants, once the CR got through and we knew what we were working with. So all during that period the continuing grants were funded.

Senator SCHMITT. Now, capping indirect costs at 9 percent and making a 3- to 4-percent reduction in the average cost of research project grants enabled you to reach 4,100 grants; right?

Secretary SCHWEIKER. That's right.

Senator SCHMITT. So the situation is even more serious than the number of grants would indicate, in terms of how far we departed from our original goal of 5,000 grants.

Secretary SCHWEIKER. Well, compared to the 5,000-grant goal it is; yes.

Senator SCHMITT. It is my understanding that just to get back totally in all aspects, including indirect costs and average costs, to the 1982 level, would take something like $223.6 million. Does that roughly jibe with what you all have figured? I'm trying to phrase this so you don't have to violate the memorandum of David Stockman.

Secretary SCHWEIKER. I detected that. [Laughter.]

It almost sounded like an A-10 question, but not quite. [Laughter.]

You're going on a 5,000 base now?

Senator SCHMITT. No; the 1982 level of 4,741 and 9,702 research grants.

Secretary SCHWEIKER. Your figure was what, again, Mr. Chairman?

Senator SCHMITT. $223.6 million. That's basically the 1982 level.

Secretary SCHWEIKER. Is that $223 million beyond the $180 million, or does that include the $180 million?

Senator SCHMITT. That's partly what I'm trying to figure out. I think it's beyond $180 million.

Let the record show there is at least one head nodding.

Secretary SCHWEIKER. I would say that that is approximately right, Mr. Chairman, and I am glad you asked me with the preposition with the clause first instead of the other way.

Senator SCHMITT. As you might suspect, Mr. Secretary——

Secretary SCHWEIKER. Your assumption there, too, was to restore the indirect costs?

Senator SCHMITT. That would be the 1982 level of activity, types of activity level.

Secretary SCHWEIKER. That's our understanding.

PROBLEM OF DRUG ABUSE AMONG YOUTH

Senator SCHMITT. It would be $223.6 million plus $108.5 million.

Moving on to ADAMHA, an area of particular concern to First Lady Nancy Reagan is the problem of drug abuse among young people in the United States. How will the fiscal year 1983 budget serve to address the growing problem of drug abuse among young people?

Secretary SCHWEIKER. Well, again, part of the money in the ADAMHA program was block granted to the States because it was not basic research. The basic research component we're administering here. OMB cut ADAMHA funding but I appealed it and got level funding. So I got level funding, but obviously that means we fund fewer projects.

Senator SCHMITT. Mr. Secretary, have you been consulted in the development of the south Florida task force effort by the Vice President, or under the direction of the Vice President? Are you familiar with the south Florida task force?

Secretary SCHWEIKER. Yes; I have been consulted and have talked with the Vice President about it. This is his task force?

Senator SCHMITT. Yes.

Secretary SCHWEIKER. Right. And I'm a member of the task force.

Senator SCHMITT. One of the concerns that some of us have had is that in concentrating your available enforcement resources along one portion of our vulnerable coastline or borders, and with a great deal of publicity in so doing, you encourage the flow of drugs to move to other parts of our coastline and/or border. There is already some evidence that that has occurred and that the traffic along the flyways through New Mexico and Arizona has increased since the publicity surrounding the establishment of the south Florida task force.

I communicated with the Vice President about it and got an innocuous letter back not satisfying anybody. Do you see the indirect effect of this? Drug abuse will increase away from south Florida as a consequence of the task force. That should be taken into account in the distribution of funds for drug abuse.

Secretary SCHWEIKER. Certainly, as a member of the task force, Mr. Chairman, I'd be glad at our next meeting to discuss the subject. I think it's a valid point and, although obviously I am not chairman of the task force, the Vice President is, I'd be glad to explore that with him as part of our task force's responsibility. I think we'd obviously want to control entryways wherever they occur. We certainly don't want to give one area a priority over others in getting enforcement protection, so I certainly feel that's a good question. I'd be willing to pursue that at our next meeting of the task force to see what can be done.

The biggest bulk of the problem, I suspect, is in the Florida area, but I think we have a problem in other areas.

DRUG LAW ENFORCEMENT FUNDS

Senator SCHMITT. Mr. Secretary, the bulk of the problem is we don't have enough enforcement personnel or equipment, so any time you decide you're going to have a task force, you have to requisition the personnel and equipment from other areas in order to operate that task force. It's my understanding we have only six customs' interdiction pilots to cover the area between Louisiana and Arizona. As a consequence, the sophisticated drug runners know exactly where to go in order to get across our borders. That's not your problem, but what you can count on is an increase in drugs moving into and through States other than south Florida.

The administration has steadily cut back or at least has not increased the availability of funds for drug law enforcement activities. The Customs Service and the Coast Guard have been particularly affected by cutbacks.

Secretary SCHWEIKER. Mr. Chairman, as I say, we are considering a possible supplemental in this area of enforcement. At this point it hasn't been officially decided, and no action has yet been finalized. I don't want to mislead anybody that that decision is made.

Senator SCHMITT. It's not your area of budget, but since you are on the task force I hope you will assist me and others to get this discussion on a somewhat more rational basis. I'm all for task forces. They've been very effective. The cooperative efforts 2 or 3 years ago by the Coast

Guard and the Customs Service in the Florida area showed that combined operations under a centralized command can work very well, but that experience has not resulted in any development of centralized control of air interdiction or sea interdiction efforts or increased equipment necessary in order to conduct those efforts. There have been some funding increases as a result of congressional activity, but your difficulty is, that the block-grant approach—which distributes funds according to formula—doesn't take into account how the drug traffic may shift as a result of the law enforcement task forces.

Secretary SCHWEIKER. It's true. It's based on that distribution formula. Unfortunately, that's true. But I'll be glad to raise this issue at the next meeting of the task force.

PLANS TO INCREASE PARENTAL INVOLVEMENT

Senator SCHMITT. Do you have plans to increase parental involvement in the drug abuse awareness efforts comparable to those that you are considering for the birth control effort?

Secretary SCHWEIKER. We are planning to step up our activities on parental involvement and that's what Mrs. Reagan is obviously trying to do in the private sector. We certainly are going to try to do it in the public sector.

Senator SCHMITT. Are there any specific plans? I know she's very interested in it; I just am wondering.

Secretary SCHWEIKER. I'll be glad to send you the specifics. Our ADAMHA people aren't here, but I'll send them down. Mrs. Reagan is working with the private sector. But she's not involved in the public sector per se.

Senator SCHMITT. I understand, but it would seem that there might be some supportive activity.

Secretary SCHWEIKER. We'll get you some information on that.

Senator SCHMITT. On the part of the Department.

Secretary SCHWEIKER. Right.

[The information follows:]

PARENTAL NOTIFICATION REGARDING DRUG TREATMENT

There are no plans to require drug abuse treatment programs receiving Federal funds through the alcohol, drug abuse, and mental health block grant to notify parents whose children receive drug abuse treatment. We believe this is an issue that should be decided by the States, since they administer the block-grant funds and since current State policies vary. Some States require the consent of the parents of children under 18 before they will provide drug abuse treatment; other States have no such requirement.

ELIMINATION OF CLINICAL TRAINING FUNDS

Senator SCHMITT. The budget for fiscal year 1983 eliminates all funds for clinical training in the area of mental health, drug abuse and alcohol abuse, at the same time the report of the Graduate Medical Education National Advisory Committee indicates that there will be a shortage of psychiatrists and other mental health care professionals over the next decade.

How do you rationalize budget cuts with that report?

Secretary SCHWEIKER. Well, since 1963 the supply of psychiatrists has almost doubled, going from 16,000 in 1963 to 30,000 today. Psychologists have gone from 20,000 in 1963 to 40,000 today, and registered nurses in the mental health field have also increased. I don't have the exact figures for nurses.

So the point is that the number of psychiatrists and psychologists have doubled since 1963. I guess the question is: Is that enough or not? But it's something you should keep in mind.

SHORTAGE OF CLINICIANS

Senator SCHMITT. Well, I have not read the report. I don't think they said that there's a decline, there is a shortfall.

Secretary SCHWEIKER. But if your supply has doubled, then I guess you have the question as to how high a priority we should set for more training in terms of spending.

Senator SCHMITT. If you need 1 million soldiers and you start with 1 and you get 2, that's doubling the number of soldiers, that's not necessarily filling the need.

Secretary SCHWEIKER. No; but we started with 16,000 and 20,000, respectively. The Federal effort has always been very small. We've never provided more than 5 percent of the national expenditure, so what we do in terms of an increase or decrease won't have that much impact, because it's never been more than 5 percent of the total training dollars in this area.

Senator SCHMITT. So your argument is that whatever the shortage may be, that the Government has not had a significant role in filling that shortage in the past, and, therefore, elimination of the program will not have a significant effect.

Secretary SCHWEIKER. In addition, our manpower pool has doubled since 1963, so it isn't a crisis situation.

Senator SCHMITT. Well, I don't know whether it's a crisis; I don't know how many you or the Advisory Committee believe are necessary. That's what I'm trying to say: I don't know whether 16,000 is enough or 30,000 or 100,000 for that matter.

When we look at a $70 or $80 billion industry in the use of drugs in this country, then I have no idea what is sufficient in order to provide assistance to those that have turned to drugs for whatever reason they might have.

Secretary SCHWEIKER. Of course, I'm not convinced that there is a direct relationship between the number of psychiatrists and psychologists and how you treat drug abuse either. I'm not sure there is a direct relationship in that respect. Maybe there is, I don't know.

Senator SCHMITT. It doesn't sound like either one of us know enough to judge on this budget item; is that correct?

Secretary SCHWEIKER. I guess so.

Senator SCHMITT. Well, maybe we can pursue that in a little more detail.

Secretary SCHWEIKER. I think Dr. Mayer, who is an expert in the area, thought it was a lower priority. All the time I must make very unpleasant choices: we cut here, we cut there, we have to add here. We just felt it was a lower priority item in the total picture.

[The information follows:]

PHASEOUT OF CLINICAL TRAINING

There appears to be no doubt that there is a shortage of psychiatrists. This is not presently the case with respect to psychologists, however, where the current supply appears to be adequate. We expect that the zeroing out of mental health clinical training will not significantly affect the supply of mental health personnel. The States currently devote a sizable share of their budgets to their universities, and have a substantial interest in continuing those programs which are responsive to State and local needs. It is in their interest to make up the relatively smaller percentage of funds which were provided by the Federal Government, unless the programs are deemed irrelevant to State requirements.

CLINICAL TRAINING

Senator SCHMITT. Well, Mr. Secretary, I think the thing that's caught our eye is the very rapid dropoff in funds for clinical training. Obviously, at one time it was considered important enough to fund. For example, in 1981, almost $62 million was spent on clinical training for mental health activities. It dropped to $44 million in 1982—$45 million—and then to zero now requested for 1983.

That is going to have an impact on a number of institutions that have been turning out these kinds of professionals. That doesn't answer the question whether it was necessary funding—we may have been wasting all of that money all of these years—but we have to ask the question of what is the impact.

Secretary SCHWEIKER. I think the new element, Mr. Chairman, is we're facing $100 billion deficit. We weren't facing $100 billion deficit 1 year or even 2 years ago.

So I think, frankly, on the basis of $100 billion plus deficit you have to change priorities and you have to feel clinical training isn't one of the highest priorities.

Now, if the number had dropped from 16,000 down to 8,000, instead of doubling, I would say that maybe we're wrong. But with it doubling over the last two decades, I have trouble understanding that this should be the highest priority.

Senator SCHMITT. I don't think we're arguing the highest priority. We're merely trying to get some information on why decisions were made to enable us to either concur in or modify those decisions.

The $100 billion deficit is not going to be solved on the basis of any level of cuts in discretionary programs, even though budgetary restraint is clearly the name of the game, and I believe in it very much. That particular problem is going to have to be solved in other ways—we're not going to solve it in this budget—that's for sure, or in this bill.

CUTS IN DISCRETIONARY AND ENTITLEMENT PROGRAMS

Secretary SCHWEIKER. Again, though, remember my chart. The rate of spending increase in my Department dropped from 17.8 percent down to 10 percent, so with a $200 billion base we did make some progress last year.

Senator SCHMITT. But as I also said earlier, we did it on the backs of discretionary programs.

Secretary SCHWEIKER. Yes; that's right. But we'll never do the job, unless we put the two together. It has to be a combination of discretionary cuts and entitlement cuts.

I agree with you about entitlements, but you can't ignore discretionary programs. I concur it has to be a balance, and we haven't balanced it so far.

Senator SCHMITT. You're right about that: It's totally out of balance at this time.

Secretary SCHWEIKER. But I made that proposal last year, and I got shot down in flames with the entitlement cuts I recommended last year.

So I have to say that the climate is not very conducive to entitlement cuts, Mr. Chairman. I was leading the charge on social security, but I went down in flames for that. I've done it both ways, Mr. Chairman. I've cut discretionary; I've cut entitlements. It's pretty hard to cut discretionary programs if you don't cut entitlements. I've done my duty on both.

DECLINE IN NURSES

Senator SCHMITT. Unfortunately, last year we were able to make some progress on discretionary. I suspect we are not going to be able to make any more progress—if you call it that—on cutting discretionary this year. At least not a significant amount, and that's our problem.

Institutional assistance for nursing programs consists of the advanced nurse-training program, the nurse practitioner program and the special project program. A recent report on the supply and distribution of nurses by the Health Resources Administration predicts a sharp decline in the number of graduations from schools of nursing by the year 2000. It also notes that projected needs by the year 2000 exceed the supply estimates.

Do you have any comments relative to this study?

Secretary SCHWEIKER. Which study was that you're talking about?

Senator SCHMITT. The Health Resources Administration study apparently issued sometime last month would be my——

Secretary SCHWEIKER. OK, we have a copy of the study. What's your question about it again?

Senator SCHMITT. The study, as I understand it, predicts a dropoff in the number of graduations from schools of nursing by the year 2000, and that projected requirements will exceed the supply by that date.

Secretary SCHWEIKER. Unlike the psychiatrists and psychologists, Mr. Chairman, this is a different story. I think here, clearly, there is a shortage—no question about it.

The problem is, though, how to remedy the problem. I frankly think that the problem is that we aren't paying our nurses enough. If we don't upgrade the job, if we don't give them career benefits and pay commensurate with their workload, once they get into the nursing profession they go on to something else because they get better pay, better benefits, better hours elsewhere.

And I really think the problem is one of whether or not we're going to upgrade the nursing profession and give it commensurate pay and commensurate responsibilities.

Senator SCHMITT. How do we do that?

Secretary SCHWEIKER. Well, I think it's something that the providers and the dispensers of health care have to deal with. It's difficult to mandate that from the Federal Government.

I think what's happening is that many hospitals are now experimenting with some innovative ways of upgrading the nursing role and benefits. For example, some of them are looking at paying nurses for a 2-day, 12-hour weekend shift, so that the hospitals can get nurses who will be paid for a week's salary, but will work 2 12-hour days on Saturday and Sunday, the days when some working mothers would like to work to supplement their families' income so they don't have to work during the week.

I think another way is to reward clinical performance on an incentive basis so nurses can advance in salary and not be frozen just where they are now.

I think another way is to give the nurse practitioner more responsibility through reimbursement plans, in the clinical procedures, so they can play a larger role.

I think there's a whole kaleidoscope of things that we must do; otherwise, nurses will just move on to greater challenges and greater opportunities and I can't blame them. There's no quick answer to it.

Senator SCHMITT. Doesn't better compensation work against your efforts to reduce hospital costs?

Secretary SCHWEIKER. You're right; it does. But I have to acknowledge that I think that's something we're going to have to do for nurses, if we want to keep them in the system. And I happen to think they're an important part of the system.

I believe it's a necessity if we want to keep our nursing profession.

HHS PLANS TO ENHANCE THE NURSING PROFESSION

Senator SCHMITT. Does the Department have any specific initiatives underway in order to try to encourage the enhancement of the quality and remuneration of the nursing profession?

Secretary SCHWEIKER. We have some.

Senator SCHMITT. I mean the quality of work environment not the quality of nursing care provided.

Secretary SCHWEIKER. We do have some research underway financed by the Department to stimulate a change in the health care industry. In fact, the three most authoritative studies about why people leave the nursing profession were financed by our Department.

But frankly, it's going to take a lot more than studies. It's going to take motivation to see the nursing profession as something different from how it has been viewed in the past by the rest of the health professions, whether it's the hospital or the doctor or the administrator.

I think that's an attitudinal change and it's not too easy. But unless we change attitudes, we won't solve the problem. On the other hand, I think hospitals that have shortages are getting pressured to do those kinds of things, so the ones that are worst hit are now taking steps. It's just a very slow, painful process. There's no quick and easy answer.

ADVANCED TRAINING OPPORTUNITIES FOR NURSES

Senator SCHMITT. The American Nurses' Association believes that the greatest need in nursing today is for nurses with advanced training. However, the Federal Government's efforts in advanced training have dropped off until in fiscal 1983 there will only be seven grant awards, as I understand it.

Do you have any encouragement for the nurses' association with respect to the availability of funds for advanced training opportunities?

Secretary SCHWEIKER. We did drop some funding in that area. On the other hand, I've put some emphasis on training nurse practitioners, which I think is an even better program than advanced nurse training, because I think in the long run that's one place that nurses can get more professional recognition, more responsibility, and also more pay. And I think it's an easier way to go.

But I would have to say that the Federal money isn't a great amount—it is seed money.

Senator SCHMITT. Again, is there any potential for matching fund leverage in this area of nurse training?

Secretary SCHWEIKER. Industry itself has begun to take some measures to help with this problem. I've already named some of the things. But they also are establishing child care facilities for nurses with small children, so that nurses who have family obligations can bring their children in for day care and still do nursing.

Another thing industry is doing is providing money to help nurses pursue postgraduate academic courses, which would be advanced training. The industry itself has been chipping in because of the crisis.

So there is some effort now. About what we can do jointly with the private sector, we're open to suggestions. We'll be glad to talk about it.

REPLACEMENT FOR HSA'S

Senator SCHMITT. There are no funds requested for HSA—health systems agencies—for fiscal year 1983. Mr. Secretary, what do you anticipate will take the place of Federal funding relative to health systems agencies, if anything?

Secretary SCHWEIKER. We certainly are willing to look at the role States might play in this area. As you know, the law now provides that we can let a State take over the function in this area. Some States, Alabama, Louisiana, Missouri, Nebraska, and Ohio, have already opted to do that. Although we haven't provided any money in this area, we certainly are receptive to the idea if this is going to be a growing trend and we can see some interest here. We would certainly consider something in this area.

I would say that we are not very hopeful, based on past performance, that Federal health planning programs have worked. On the other hand, some States have been successful in doing it statewide, and we're certainly willing to look at State programs in a positive way, if that is the feeling of this committee and if there's enough State support for it.

We have supported those States I mentioned under the 1982 budget that opted to operate State level programs, and that may well be something worth pursuing.

USE OF BLOCK GRANTS TO FUND HSA'S

Senator SCHMITT. Some HSA's apparently are seeking alternative means of support—private as well as State funding. Do any of the current block grants provide the opportunity for State funding of HSA's?

Secretary SCHWEIKER. They could use money from either the health prevention block grant, possibly the ADAMHA one, or the maternal and child health area. Just how many would do that, I don't know; but they could use money for that purpose within the definition of the act in terms of the service involved.

It would obviously have to be related to the specific service area, but I think the law could be interpreted in that way.

MEDICAID COPAYMENTS

Senator SCHMITT. One of the most controversial reforms of the medicaid program that you have proposed is the provision of partial payment of $1 to $2 by medicaid beneficiaries for services they receive. What effect do you believe this provision will have in the utilization of medicaid services?

Secretary SCHWEIKER. We hope it will have a positive effect. If you check the figures that I showed you in this chart this morning, when the copayment share for health care dropped from 30 percent down to 9 percent, patient utilization of health care increased substantially. That's the way health care per diem costs went up strikingly.

So we believe there is a utilization factor. We also want to make clear that if somebody doesn't have $1 or $1.50, they are not going to be refused service. We are not putting forth a proposal that denies people service if they don't have $1 or $2.

We hope that the people who can afford it will pay that, and that it will be a positive factor. But we're not going to shut the door on anybody who really, honestly can't come up with that dollar.

It's not going to be a hard and fast rule on that score. It's interesting that seven States have already asked to use this proposal—Maine, New Hampshire, Washington, West Virginia, Connecticut, California, and Ohio. These are pending. Now their requests have to go through waivers, which gets to be a very tedious procedure because the law prohibits me from approving these actions except through a waiver process.

The fact is there's a tremendous interest in this proposal among the States. They feel it is a strong factor in the degree of health care utilization. Governor Busby of Georgia was a very staunch advocate of this, and he is probably as knowledgeble as any Governor on health care costs. He's done a good job in his own State. He keeps asking me: When are you going to do it—because the law prohibits it now.

I also feel strongly that it wouldn't prohibit the person who doesn't have $1 or $2 from being served.

Senator SCHMITT. Is the budget for the medicaid program predicated on enactment by July 1, 1982, of legislative changes that are designed to reduce the cost of the program by $1.83 billion in fiscal year 1983? To my knowledge, no committee in Congress has even begun the serious study of your proposals. What will be the effect on your overall fiscal 1983 budget if none of the entitlement proposals are accepted?

Secretary SCHWEIKER. That was an optimistic assumption, Mr. Chairman.

Senator SCHMITT. Well, we will do the best we can to help you.

Mr. Secretary, let's see, we have covered the swing bed some this morning. Why don't we take a quick break here so I can run and vote, and I will be right back? I will be about 10 minutes.

[A brief recess was taken.]

MEDICARE CONTRACTORS

Senator SCHMITT. Mr. Secretary, the committee believes that the performance of the medicare contractors who handle claims processing for medicare beneficiaries is crucial to the efficient expenditure of Federal health care dollars. In fiscal 1982 medicare contractors received $711 million, now $14 million below the subcommittee's recommendation of $725 million. I might add, the committee had to fight off, as you did too, an attempt by OMB to reduce this budget to $624 million. In fiscal 1983 the administration is requesting $704 million.

How do you rationalize these numbers? Can medicare contractors be expected to process a higher volume of claims with less money than they had in the last fiscal year?

Secretary SCHWEIKER. Well, this is one area where we have a dispute with OMB as well. I concede that the medicare contractors have a difficult burden. We have lost one already, and it is a tough issue. As I recall, we requested more money for this. So it is an area where we have an honest difference with OMB, but this is our request. We will try to live within it.

We are certainly putting more stress on administrative requirements for the reasons that you mentioned, and whether they can apply efficiencies and economies to make up the slack is an open question. We have already lost one contractor. Nationwide has decided they no longer like our program.

On the positive side, we do hope that some ADP technology will give them more productivity. We are hoping that is going to be a factor.

One thing that isn't necessarily a factor here, but I would like to mention, Mr. Chairman, is that just recently we finally resolved the form question and we now have one form which we believe is acceptable to all the providers in the whole system. So, instead of having literally hundreds of different forms, different colors, different columns, different figures, we have adopted for the first time a standardized form. We expect this to save millions of dollars and make their job somewhat easier.

I don't want to say that that is an answer to the problem. But it is a significant accomplishment; we are rather proud of it. There was a lot of headknocking and armtwisting to get a lot of different people to agree to use one form.

Senator SCHMITT. When during the year do you normally see whether or not the funds available are going to be adequate for the job? Another way to put it is, when can we expect to see evidence that reprograming or supplementals are going to be required?

Secretary SCHWEIKER. We are in the process of doing that now. I guess that is the best answer we can give you.

Senator SCHMITT. Would you provide for the record some details on how you think you are relieving the burden on medicare contractors to compensate for some increased amounts of utilization review that are mentioned in the budget statement?

Secretary SCHWEIKER. We will do that.

[The information follows:]

UTILIZATION REVIEW BY MEDICARE CONTRACTORS

HCFA is conducting a medicare administrative reform initiative—MARI—to enable medicare contractors to operate more efficiently and cost effectively in addition to assuming increased utilization review responsibility.

The MARI was designed to streamline and to restructure the administration of the program so that routine claims payment operations can be performed in a less costly manner. The MARI is being carried out in cooperation with the medicare contractors, who have contributed a number of streamlining proposals which are now under review. HCFA staff have also visited contractor locations conducting analyses of the operations to uncover areas where efficiency can be improved. The MARI also includes a stepped-up effort to increase the number of bills sent to the medicare contractors in an automated—paperless—fashion as well as an intensified effort to improve or remove inefficient contractors.

A major component of MARI is the cost/burden reduction—C/BR—initiative to identify Federal requirements which impede efficiencies in contractors' administrative activities. Examples of cost-savings initiatives which the contractors have been instructed to implement beginning in fiscal year 1982 include: a 40-percent reduction in the part B carrier's quality assurance sample sizes, which can be adjusted without compromising statistical validity; suspense of the annual drug survey; elimination of explanation of medicare benefits statements on certain assigned medicare cross-over claims; and a reduction of part B claims development activities. Approximately 50 additional proposals are in various stages of development as part of the C/BR initiative.

In addition to lightening the burden on medicare contractors, these initiatives will produce savings which can be applied to absorbing increased workloads and inflation, as well as to increased utilization review activity.

ZERO-ERROR RATE GOAL

Senator SCHMITT. Do you believe, Mr. Secretary, you can achieve a zero-error rate in medicare SSI programs which are administered solely by the Federal Government by the end of 1986 or ever? Is that a symbolic goal or is it something you really believe in?

Secretary SCHWEIKER. Well, the first proposal, Mr. Chairman, was to achieve it at the beginning of this next fiscal year. That was the first proposal I had presented to me, that we were automatically going to achieve it by October 1. I had to reject that proposal. So this is the best thing I could get agreement on—a phase-in situation—because originally OMB asked us to have a zero error rate effective October 1.

Senator SCHMITT. Of course, scientifically and technically, that is a ludicrous thing to shoot for, but politically it is not a bad idea.

Secretary SCHWEIKER. Let me say in fairness to OMB, there are some States that have done pretty well. Illinois, Maryland, Oklahoma, Virginia, Missouri have error rates under 3 percent.

Senator SCHMITT. I understand that, and that is super, and I think we ought to push and shove and set realistic schedules and goals out there. There is a deity called the zero error rate. But let's be absolutely clear to everybody that there is no such thing as a zero error rate in programs administered by human beings, keypunched by human beings, which are of the magnitude that we are talking about here. But we certainly can do a lot better, as the evidence of several States have indicated.

Secretary SCHWEIKER. Nebraska has a 1 percent error rate and Minnesota half a percent. So some have done really well. I don't disagree with the premise.

Senator SCHMITT. The problem is if you set it too much as a goal at that low level, the incremental cost to reach the next quarter of a percent is an awfully large cost.

Secretary SCHWEIKER. I think that is the key question. There are about 10 States in the 2- to 1-percent rate of error category, and it gets awfully expensive to get that last half a percent. I think that is something we have to analyze.

LOWER ERROR RATE STATES

Senator SCHMITT. What about the experience of those States that have done well? Is there a mechanism for transferring that experience to other States?

Secretary SCHWEIKER. OMB has done some of that, Mr. Chairman. OMB held a conference in January where they called all the States together specifically on this question. I think the experiences of some of these States encouraged the others to change things, but different States have different problems. It is not as easy to achieve low-error rates in all States as some of these are achieving. But they did have a conference specifically on this subject, where the States told how to do it from their experience.

Senator SCHMITT. Could you provide for our record a few of the generalities of what appears to be the reason for a low error rate in one State versus a higher error rate in another?

Secretary SCHWEIKER. All right.

[The information follows:]

Every rate varies according to the complexity of the State AFDC and medicaid programs, the sophistication of automatic data processing systems, the commitment of top management to error rate reduction, the adequacy of staff resources, and other factors such as the percent of clients who have difficulties with the English language.

Senator SCHMITT. Is there any consensus on what are the systematics here?

Secretary SCHWEIKER. I think one thing that relates to how well they have done is motivation. Let me say Mr. Chairman, that we recognize how difficult it is. We have been waiving penalties until now. As you know, the law does provide for some stiff penalties. So I have been very understanding about getting error rates down. But we are running out of time, and I will be required to put no waivers through after the Michel amendment is fully effective. Then there will be penalties for not getting below the 4-percent error rate and an intermediate step.

[Pause.]

Secretary SCHWEIKER. There are good illustrations that our previous actions have stimulated some real progress. For example, Maine had an 18-percent error rate, and they dropped to 8 percent as of March of last year. We have had others that have dropped, not quite as much, but Arkansas went from 11 to 3 percent. Because of our auditing and encouragement, Iowa went from 11 to 3 percent.

So, there is some progress, but just how much lower error rates can go is another question.

Senator SCHMITT. If you could provide some of what appear to be the reasons for good performance and the reasons for bad performance for our record, it would be helpful.

[CLERK'S NOTE.—Information regarding error rate variances among States is presented on the previous page.]

COLA CHANGE

Senator SCHMITT. Mr. Secretary, I am very familiar with the President's position that he does not want to undertake any kind of a freeze of COLA's at this time. There has been some discussion in gearing all COLA's and pay increases to the current rate of inflation rather than existing formulas that utilize the CPI. In the case of social security, I understand that the COLA increase relates to a CPI that is 16 months old.

Is my understanding correct, that if there is any adjustment in COLA's, for it to have a major effect, that has to be done by a certain date in order to be able to process the checks that would be mailed out?

Secretary SCHWEIKER. Your presumption is basically correct. We are talking about dates for the cost-of-living adjustment that is to be given in July. We are getting into a very critical time right now. However, if, for example, you are talking about delaying the cost-of-living increase for a few more months, then obviously that would give us some more time.

Senator SCHMITT. But if you were talking about a cap rather than a delay?

Secretary SCHWEIKER. We are running out of time.

Senator SCHMITT. Within 2 months of the mail date?

Secretary SCHWEIKER. May 8.

Senator SCHMITT. That is when the processing begins?

Secretary SCHWEIKER. And let me say it would be a tremendous cost and tedious process after May 8 to do it because of the changes that would take place. If you are not moving the date back, don't readjust the COLA. If you are moving it back a few months, then you gain some months. But you are right.

COUNTERFEIT-PROOF SSA CARDS

Senator SCHMITT. What is the status of a counterfeit-proof social security card? Is there an ongoing proposal or study on this?

Secretary SCHWEIKER. We have two different levels of work on that, Mr. Chairman. No. 1, we have taken some security steps. We had a GAO study that showed a while ago there was very loose security about the availability of social security cards. So we are tightening up the security.

Senator SCHMITT. You are talking about blank cards?

Secretary SCHWEIKER. Yes; so we have taken some administrative procedures concerning security. On the other issue of foolproof security cards, the problem is how far you go on cost. Some of our figures show great expense for a really foolproof card. We do have a system under study now as to how much the cost should be. We were doing it for one of the task forces out of the White House, and it got to be quite an expensive proposition.

The real problem is that we give a social security card now based on the baptismal certificate or the birth certificate. So you can make a foolproof card, but if people come in with false baptismal certificates or false birth certificates from the various States, your foolproof card won't be any good. And that is part of the problem now.

Now, unless you want to go back and have each State guarantee its birth records are going to be foolproof or its baptismal certificate records foolproof, there will be problems. So, a chain is only as strong as its weakest link, and right now one of the weak links is with birth certificates and baptismal certificates. Unless you want to mandate the 50 States on the way they issue birth certificates and have a national birth certificate file and register, it becomes awfully difficult to assure accuracy, because you can put false data on your card. Anybody can get a card if they have a false birth certificate, and it is pretty tough to tell a State how to tighten up on that.

Senator SCHMITT. I think that is an excellent point to make. There have been a lot of press reports that so-called smart cards or other things can be foolproof, but you are absolutely correct, it depends on the data used to issue the card. Once it is issued, presumably it can't be used.

Secretary SCHWEIKER. We can come up with a card that is foolproof, but the problem is it costs a lot of money and the system will be only as strong as the birth certificate information.

Now, if you want to go one step back and mandate that the States must have some kind of national register or foolproof their birth certificates where we have a way of checking birth certificates, then you could probably make the whole system foolproof. But birth certificates are the weak link in our system.

We studied this for the Justice Department, based on the illegal alien bill, and we came up with this very difficult question of what do you do with 50 States' records of baptism or records of birth.

FINGERPRINT SSA CARDS

Senator SCHMITT. What about the record of existence; namely, the fingerprints? Has that been studied? Can we computerize fingerprints as an identification technique?

Secretary SCHWEIKER. Again, that would make the card foolproof in itself, but if the input material is wrong, you are still back to the same problem. We did discuss that in our task force on refugees, with illegal aliens, and it comes up against the same problem. If somebody comes in with a false certificate, then they are still in the system.

Senator SCHMITT. But with the fingerprint system, a person can really only use the card once, they can't use it twice.

Secretary SCHWEIKER. Yes; but they can get in.

Senator SCHMITT. You only issue one card to one person with a fingerprint on it. Do you see what I am saying?

Secretary SCHWEIKER. That wouldn't solve the illegal alien problem.

Senator SCHMITT. No, no, I am not trying to solve the illegal alien problem.

Secretary SCHWEIKER. That is where a lot of our cards are.

Senator SCHMITT. But it still means there is only one card per person. That is the advantage of the fingerprint. It doesn't solve the problem of falsifying a birth certificate, but it does solve the problem of multiple cards.

Secretary SCHWEIKER. We were looking at it from the standpoint of illegal aliens, and I guess we just discarded it because it wouldn't solve that problem.

Senator SCHMITT. The illegal alien problem is not going to be solved by a voter identification card in my opinion, or worker identification. The committee notes that the Social Security Administration is planning to borrow forward roughly $929 million for a shortfall in the estimate for the AFDC program costs. Taken on its face, this represents a nearly 15-percent underestimate of program cost.

Does it appear that the Department is making unrealistic estimates of savings from the legislative proposals that it has made?

AFDC COST UNDERESTIMATES

Secretary SCHWEIKER. Well, there are several factors, Mr. Chairman, that contributed to that. First of all, there were about $367 million in savings that weren't realized from the reconciliation modification. In other words, reconciliation changes were implemented by the States slower than we expected. Half the States then changed to their standards of need or payment, which increased AFDC costs. So our AFDC costs were based on what the States' need definition was at the time we passed the bill or at the time we made the survey. Some States apparently decided to increase that cost standard, which they are entitled to do, and they did.

The other thing is we had some lawsuits that delayed implementation. I think I have already told you I have 24,000 lawsuits. People love to sue to get money. They sued and delayed the implementation of a regulation. Then, obviously, we lose months of the savings that we calculated. That also happened.

Finally, there was an increase due to the changes in economic assumptions and to the demographic assumptions in terms of increased caseloads because of higher unemployment.

Senator SCHMITT. What can we expect for 1983? Do you have a similar level of uncertainty?

Secretary SCHWEIKER. Well, one way we are trying to hold costs down is our proposals to save $1 billion. But how can you predict what 50 States are going to do? That is part of our trouble. It is like predicting a moving target.

Or can you predict what a Federal judge will tell me?

We might put a regulation out and say it is going to be implemented May 1. The judge says, "No, you didn't go about this right, and you have to wait until July 1," or "You have to go to court and win your case at a lower level." And the court cases involving States are somewhat out of our control.

On the other hand, we are going to try to give you the best answer we can, Mr. Chairman. That is about all we can do, I guess.

Senator SCHMITT. Well, I realize, and I am sure the subcommittee will also, the uncertainty that you deal with in this program, particularly court action. But I think what we are trying to get a feeling for, Dick, is how certain is the figure that you requested. Is it based on an optimistic assumption of what is going to happen out there in the courts in the 50 States or a pessimistic assumption?

Secretary SCHWEIKER. We went on the budget assumption, made for the budget. These didn't assume 9-percent employment, for one thing. We must use OMB's assumptions, and they were wrong in their assumptions about the recession. So we are off in terms of the 9-percent unemployment rate, for one thing. That is part of it.

But we did ask for about $1.1 billion in legislative changes, and, frankly, if we don't get them, then the budget is off another $1.1 billion. So there are some costs here that are escalating that we have to confront one way or another.

UNEMPLOYMENT RATE IMPACT

Senator SCHMITT. Have you prepared a revised budget estimate that includes the current unemployment rate?

Secretary SCHWEIKER. We do that when the July update is prepared. That's more accurate than the earlier one because it is closer to the start of the fiscal year.

So we will do it in the July update. We'll be glad to work with the committee on that.

Senator SCHMITT. We may want to discuss it with you in a preliminary manner, if we could, Mr. Secretary, depending upon when the House begins to act. We might actually get into a markup.

The Department has sent to the committee a request to reprogram $48 million in Cuban-Haitian domestic assistance funding, $35 million of which would be used to target assistance to States with a high concentration of entrants and $35 million for cost reception and processing.

It's clear the Department needs reprograming authority for the $13 million for reception and processing, since the amount available—$19.2 million—was set in the committee report, and you propose to increase that amount to meet additional costs.

It appears that the Department also needs reprograming authority for targeted assistance funds, since this is a considerable sum of money for an activity which the committee has never previously funded.

Senator SCHMITT. Well, it's my judgment that the reprograming is needed. We're just trying to clarify with you whether that was your judgment also.

Secretary SCHWEIKER. Yes; that's right. We concur.

VOCATIONAL REHAB TRANSFER TO HHS

Senator SCHMITT. The administration proposes shifting vocational rehabilitation programs from the Department of Education to the Department of Health and Human Services.

What steps are being taken to prepare for this proposed transfer in the event it's approved by the Congress?

Secretary SCHWEIKER. Well, this is premised on the Department of Education becoming an independent entity.

Senator SCHMITT. I think it's tied to that particular proposal, yes. Would that not occur unless the Department reorganization occurred?

Secretary SCHWEIKER. That is correct. It would only occur if the departmental status of Education is changed. The impression I got on the Hill was that there was some question whether that would occur.

But we will prepare for it. It was a difficult situation with the Community Services Administration, where we didn't have adequate notice and it was just dumped in our laps through no fault of this committee. So we really had to play some catchup ball.

Here we've been put on notice; we have some experience now in view of what happened with the community services program. We certainly will take every reasonable step to handle it.

I think the vocational rehabilitation program is the case where the Department had the program originally, so the transfer won't be so difficult because we're familiar with that program. Some of these same people used to work with us, so there is no serious problem here.

But I don't believe the transfer will occur until Congress decides to approve the change in the status of the Department of Education.

Senator SCHMITT. So the planning for fiscal 1983 vocational rehabilitation activities still lies within the Department of Education?

Secretary SCHWEIKER. We did request funds for that program in the budget. I think this is where it's a little confusing, but the request in the budget was contingent upon the Department of Education changing its status.

Senator SCHMITT. I understand that. But I'm just curious how the actual program is going to work until the Congress makes its decision.

Secretary SCHWEIKER. Education will continue with it.

Senator SCHMITT. So you're just laying the groundwork to be able to assume it, should it come your way, but the Education Department will continue implementing the program at this time.

Secretary SCHWEIKER. That's right. Secretary Bell felt this was the place to put it. We had the program originally and that was his recommendation. I guess OMB concurred. We didn't seek it.

CSA THIRD QUARTER BLOCK GRANTS

Senator SCHMITT. It's my understanding that the States have not yet received their third quarter allocation of funds for community services block grants, which they normally would have received on April 1.

Can you explain why this is being delayed?

Secretary SCHWEIKER. There should not be any problem. Are you sure that this is correct? We will doublecheck; there shouldn't be any problem at all.

Senator SCHMITT. Please check on that. It's our understanding that the checks are in the mail but not received.

Secretary SCHWEIKER. My Assistant Secretary for Management and Budget says he issued the spending policy the 1st of April, so funds should have gone out right after the 1st of April—after the CR passed. We'll check and find out the amount. There's no reason for it.

Senator SCHMITT. Unless the Government ran out of money.

Secretary SCHWEIKER. It didn't yet.

Senator SCHMITT. Not yet.

Secretary SCHWEIKER. We'll try to get back to you in a day, Mr. Chairman. There shouldn't be any bottleneck here.

SUBMITTED QUESTIONS

Senator SCHMITT. Well, Mr. Secretary, we will have, as I indicated, a number of questions for the record. You recognize it is not only a terribly complex budget, it's a terribly complex time, knowing when we actually are going to be able to proceed with a markup with either the input of the House or the constraints of budget allocations in the Senate.

I see no reason to expect that at the very least the committee will report out a bill as we did last year, and we'll be working with you very closely as we develop any modifications to the present budget that the committee may determine are necessary, or that you may find you wish to recommend as the next few months go by.

This is not a static time—I recognize that—and we'll be most receptive to your recommendations.

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY THE SUBCOMMITTEE

CSA BLOCK GRANT

Question: Mr. Secretary, can you please explain why allocation of Community Services Block Grant funds is being delayed?

Answer: Block Grant allocations were delayed for a short period while determining whether State allocations would be issued for the balance of the fiscal year or only for the third quarter through June 30, 1982.

Question: When do you expect the allocation will be made?

Answer: Block grant awards to States were made on April 19.

Question: Will this allocation be adequate for the remaining two quarters, or for the third quarter only?

Answer: The awards issued on April 19 to the States are for the third quarter only.

LAWSUITS BY COMMUNITY SERVICES ADMINISTRATION EMPLOYEES

Question: What is the current status of the lawsuit filed against the Department of Health and Human Services by the former employees of the Community Services Administration?

Answer: Appeals by former employees of the Community Services Administration are currently before the Merit Systems Protection Board in the Office of Personnel Management. The Board is consolidating action on approximately 300 appeals. Hearings have tentatively been scheduled for the first week of June, 1982.

Question: How many former Community Services Administration employees have you hired as a result of the lawsuit filed against the Department of Health and Human Services? Are these permanent or temporary jobs?

Answer: The lawsuit required that CSA employees be given permanent appointments in areas determined to be a transfer of function. To date 150 CSA employees have been given permanent appointments and approximately 51 temporary appointments.

Question: What are the implications of the lawsuit for plans to dismantle other Federal agencies such as the Departments of Education or Energy?

Answer: There are no implications. Lawsuits or the lack of lawsuits when agencies are dismantled will depend on the circumstances that exist at the time.

Question: How many States have elected to accept block grants this year?

Answer: All States and territories began administering the Social Services and Low Income Home Energy Assistance blocks on October 1, 1981. The legislation for these blocks did not provide for a transition year. The Primary Care block grant will become effective on October 1, 1982. We do not, at this time, know how many States will choose to administer that block. For the remaining four blocks, State administration of block grants is as follows.

	No of States Administering Block
Alcohol, Drug Abuse and Mental Health Services	49
Preventive Health and Health Services	48
Maternal and Child Health Services	48
Community Services	40

Question: For what reasons are some States delaying their participation in the block grants?

Answer: The most frequent reasons cited for delay in accepting the blocks was to allow more time to determine appropriate State structures to administer new program responsiblilities and, in the case of the Community Services block grant, to determine how best to allocate the funds available among local agencies.

Question: How many States have transferred funds from one block grant to another?

Answer: The National Governors Association asked this question as a part of their survey of State implementation of the block grants. Their survey--which was conducted in January and February of this year--showed that 31 States elected to use the transfer provisions of one or more of the block grants. The most frequent transfer of funds was from the Low Income Home Energy Assistance program to the Social Services block grant.

Question: How does the Department intend to evaluate the effectiveness and efficiency of State government operation of the block grants?

Answer: One of the intended benefits of the block grant legislation is to reduce State reporting to information which is essential to Federal administration and Congressional oversight. The Department will not require States to report any information that is not statutorily mandated. As a result, planning and reporting requirements are considerably reduced from those of the previous programs.

The Department nevertheless needs basic information to: (1) suggest improvements in existing blocks and provide an empirical basis for creating new ones; and (2) respond to Congressional concerns about the blocks, including legislatively required reporting. The Office of the Assistant Secretary for Planning and Evaluation, in coordination with the Department's Operating Divisions and other staff offices, is gathering information and reporting on the implementation and effects of the block grants.

Question: What kinds of data is the Department compiling on State administration of the block grants?

Answer: In accordance with the intent of the block grant legislation and regulations, the Department is not undertaking any large-scale information collection efforts which would unduly burden the States. Rather, the Department is compiling information provided in legislatively required State applications and reports, and program audits when they become available. This information is being supplemented with data available from Federal staff, documents, and records, and studies produced by non-Federal organizations such as the National Governors' Association. These sources provide information on State decision making and organization, State planning and public participation, service delivery, interblock transfers of funds, nondiscrimination, and evaluation and monitoring.

Question: We have received some complaints from States that overhead expenditures of State governments are cutting into services. What are you doing to ensure that administrative expenses of the States are held to a minimum so that funds for providers and services are not cut?

Answer: Five of the seven HHS block grants have percentage limitations on the amount of funds that can be spent by the States for administrative purposes. The Department has no authority to impose limitations on States beyond these statutory percentages. States must not, of course, exceed these limitations. If a State does exceed the percentage limitation, as determined by a State or Federal audit, the Department will institute proceedings to recover the excess funds or an equal amount from future awards.

Question: What estimates can you provide on State expenditures for administering the block grants?

Answer: Reliable data on administrative costs will not be available until much later in the fiscal year. States are not required to report this information to the Federal government, but we expect that State or private organizations will be collect this information and make it available to the public and the Department. In addition, and perhaps more important, States must provide "post-expenditure reports on the use of block grant funds. Although the form and content of these reports is determined by the State; we expect that information on administrative costs will be included in reports of most of the States.

Question: How does the Department plan to monitor the requirements of the health block grants that States spend specific percentages of certain activities, or award grants to certain entities, funded under the categorical programs consolidated in the blocks.

Answer: Under the block grants, compliance with statutory provisions is in the first instance a responsibility of the State government to be achieved through proper program administration and verified in the State audits. As you know States arrange for independent annual or biennial audits of the block grants. These audits, plus the reports that are required to be made available to the public, are the basis for assessment, by the public and interested organizations within the State, of the State's compliance with the mandatory statutory percentages.

In addition, in carrying out its statutory responsibilities to review State audits and investigate complaints, the Department will assess compliance with these spending provisions. Finally, for five of the HHS block grants (Maternal and Child Health and Social Services are the exceptions), the Department must each year conduct reviews in several States to determine State compliance with all statutory provisions of the blocks--including those relating to expenditure limitations or requirements.

We believe that these mechanisms will be effective in ensuring the public and the Federal government that State spending for required services and activities is in line with the statutory requirements.

Question: One item which we discussed last year which could possibly pose a problem insofar as the block grants are concerned was the administrative overhead issue: How do we safeguard the providers while reducing the administrators?

Answer: By removing the Federal government from State decisions on how best to structure programs, the block grant legislation makes clear that a State government is responsible directly to its citizens for determining what services to provide and how best to provide them. Excessive State administrative costs will be subject to scrutiny by the public and interest groups within the State, including groups of concerned providers. The primary safeguard is the clear accountability of State government to the citizens of the state for the quality of services and the reasonableness of administrative costs. This aspect of the legislation is fundamental to effective and efficient services.

In addition, however, five of the seven block grants administered by this Department do include statutory limiations on administrative costs, which we will enforce through our audit and enforcement activities.

Question: What success has the Department had during the last year in reining in administrative costs while protecting providers?

Answer: The interests of service providers--to the extent that they are consistent with the public need for services--are best protected by making it clear, as the block grants have done, that the primary responsibility for ensuring effective and efficient services rests with State government. To support this, several of the blocks have provisions which limit administrative costs to specified percentages -- 5% to 10%. These statutory limitations ensure that almost all of the Federal funds will be available for services. Beyond this, the most significant areas of savings, however, will occur as States take greater advantage of the flexibility allowed them in structuring programs to achieve greater efficiency and effectiveness.

Question: We have been most concerned that the States implementing the block grants will use the funds to maintain layers of local administration at the expense of cutting back on providers and essential services. What are you doing to prevent such a development?

Answer: As you know, there are limitations on administrative costs in five of the seven blocks grants. These limits will be enforced through State and Federal audit and compliance procedures. The Department has no authority to attempt to restrict administrative costs to levels lower than those specified in the statutes. However, through our audits and investigations, we will be able to identify any States that exceed these statutory limits and to seek repayment of funds that were improperly spent.

Question: What instructions, if any, do you give the States to prevent the bureaucrats from taking away service and provider money?

Answer: There are no special instructions to this effect. States have been informed of, and know, their statutory responsibilities to limit administrative costs to the amounts specified in the legislation. Public disclosure of post expenditure reports and independent State audits, as well as Federal audits and compliance procedures, will ensure that this is done.

Question: What report or bill language would assure that money for services is maximized--and money for overhead is miminized?

Answer: The limitations on administrative costs established by the Omnibus Budget Reconciliation Act are clear and I do not believe that any additional requirements are necessary. Indeed, we are suggesting some relaxation, particularly in the Primary Care block grant which allows no Federal funds to be used for State administration. The keys to achieving administrative efficiency and to maximizing the portion of funds available for services are the flexibility allowed to States to design effective and efficient services and the clarification of the State's accountability to their citizens for the quality of these services.

BLOCK GRANTS

Question: The Subcommittee is aware that the Administration may propose to amend several provisions of the Low Income Energy Assistance, Maternal and Child Health and Primary Care block grant statutes that it considers burdensome on State governments. Chief among these are provisions that restrict administrative costs, establish program earmarks and require State matching requirements, among others.

If you relax restrictions on administrative costs, won't you assure that these costs will just leave less money available for providers of essential services?

Answer: The proposal to remove the 10 percent restriction on administrative costs under the Low Income Home Energy Assistance Program was made by HHS in order to allow States to manage their programs in line with State needs and priorities. We are not recommending that more funds go for administrative purposes rather than benefits and services. Our recommendation is based on our belief that setting an arbitrary cap on administrative costs is not an appropriate Federal role when it comes to block grants. We believe that the States are able to determine their individual administrative cost requirements in line with the manner in which they wish to implement their energy assistance programs.

Question: It seems premature to provide State governments with additional flexibility when we have so little quantitative and qualitative information on State implementation of the block grants. How can you justify repeal of these provisions at this time?

Answer: We believe that States have established a track record with the energy block grant which demonstrates their ability to use the increased flexibility provided this year to design programs suited to the needs of their citizens. We have several sources of information on which to base our beliefs.

The Omnibus Budget Reconciliation Act of 1981 provided for the Secretary to consider complaints that States are not spending funds in accordance with the statute. To date, complaints have been received from only two States. Consideration of these complaints is still underway in accordance with our regulations. However, at this time, there is no indication of State abuse of flexibility provided under the block grants. In accordance with statutory provisions, we are also conducting compliance reviews in several States to assure State compliance with the statute. There has been no evidence in these reviews that States are unable to manage and control the expenditure of funds in a manner consistent with the goals set out in the statute.

A number of groups, including HHS, have surveyed States to learn about their implementation of the block grants. It was found that States are using the flexibility provided in this year's statute and regulation. In many respects, State programs are similar to last year's, which were developed under detailed Federal regulations. However, most States have used the added flexibility provided this year to provide some assistance in the form of weatherization, and to transfer some funds to other block grant programs.

In summary, we have information about State operations from several sources this year. All of it suggests that States are not misusing the added flexibility they were given for FY 1982. On this basis, providing additional flexibility for FY 1983 is justified.

Question: In your opinion, what level of Federal oversight is appropriate?

Answer: Each State has been given wide policy discretion for management of the Low Income Home Energy Assistance Program and is accountable to its citizens through a process of public review. We do not believe it is appropriate for HHS to set program policy for the States nor do we believe it appropriate to duplicate State audit and monitoring efforts. Rather, it is the role of the Federal Government to require adequate State fiscal controls and to, where necessary, build on State monitoring and audits. Any Federal review should concentrate upon the States' efforts to ensure that funds are expended in accordance with statutory guidelines.

Our experience in looking at State energy assistance programs to date indicates clearly that States are capable of implementing and monitoring programs to assure that they are consistent with the statute and regulations. Federal oversight efforts which duplicate State efforts, such as the investigation of complaints and compliance reviews under Section 2608 of the Omnibus Budget Reconciliation Act of 1981, are unnecessary and should no longer be required.

Question: For Fiscal Year 1983, the administration proposed to place the administrative responsibility for two of the health block grants--Prevention and Alcohol, Drug Abuse and Mental Health,--within the Office of the Assistant Secretary for Health (OASH). The Centers for Disease Control now administers the Preventive Block and the Alcohol, Drug Abuse and Mental Health administration administers the block relating to its area.

How much money will this proposal save over current decentralized administration of these block grants?

Answer: While we have no precise calculation of the amounts to be saved through administrative consolidation of these two block grants in the Office of the Assistant Secretary for Health (OASH), we believe cost savings will result through various economies of scale and streamlined federal administrative and technical assistance functions. In addition this consolidation will also simplify State administrative functions by providing a single PHS office contact regarding these block grants. We would continue the consolidation of staff vegun in FY 1982, with the result that staff managing the activities included in these two grants would be reduced to approximately 95 positions between FY 1981 and 1983.

MATERNAL AND CHILD HEALTH BLOCK GRANT

Question: Mr. Secretary, for fiscal year 1983, the Administration proposes to transfer responsibility for the Women, Infants, and Children and Commodity Supplemental Food programs from the Agriculture Department to the Department of Health and Human Services. Funding for the categorical programs proposed for consolidation would be decreased 30 percent below fiscal 1982 levels. How can the Administration justify a 30 percent decrease in funds for the Women, Infants, and Children and Commodity Supplemental Food programs that have been proven to be highly cost-effective?

Answer: The simplified Services for Women, Infants, and Children Block Grant will allow States to reduce significantly the current administrative costs they experience under the WIC program. The block grant will, thus, allow a higher proportion of funds to be spent on services, rather than administrative overhead.

The simplified block grant, by combining related programs and reducing unnecessary administrative burdens imposed on the States, will allow the States to improve the targeting of resources to the most needy people and the most effective activities. This improved targeting of resources will ensure that proven cost-effective activities, such as nutritional programs for expectant and breast-feeding mothers, continue. In fact, the new block grant will build on the existing arrangement where Maternal and Child Health clinics are already WIC providers.

Question: How will funding cutbacks affect attainment of such program goals as reducing infant mortality and the incidence of preventable diseases and crippling conditions among children?

Answer: Our expectation is that, in combining the MCH medical care activities with the nutrition/feeding services of the WIC program, the States will be enabled to effectively allocate resources and direct services to those in their populations who have the greatest needs or are of the highest health risk. One of the areas, for example, where WIC services have been proven most effective, and where services are vital, is that of services of expectant and breast-feeding mothers. We believe that such groups will continue to be served and that establishment of this block grant will not have an adverse effect on the infant mortality rate.

Question: Do you propose to limit Federal reimbursement for State administrative expenses associated with operations of the WIC and Commodity Supplemental Food programs?

Answer: The legislative specifications, which have been sent to the Congress, do not propose to limit Federal reimbursement for State administrative expenses associated with the operation of the WIC and Commodity Supplemental Food Programs.

PRIMARY CARE BLOCK GRANT

Question: We note that you are proposing to include the Migrant Health, Family Planning and Black Lung categorical programs in the Primary Care Block Grant. What is the rationale for this proposal?

Answer: This proposal is a significant element of the President's New Federalism initiative to identify similar and related activities and combine them into block grants. This proposal will alter the relationship between the Federal and State and local governments by shifting decision-making responsibilities to the States and enabling them to be flexible in attacking problems found within their borders.

Consolidating separate categorical grants for black lung clinics, migrant health, and faimily planning with the Primary Care Black Grant beginning in 1983 will reduce the fragmentation of current primary care services programs. Rather than being required to go to several different and unrelated grantees for primary care services, individuals in need of health care will be able to receive care within a comprehensive assistance system. This approach will reduce the multiplicity of Federal rules and regulations under which primary care service agencies currently operate.

Question: What assurances can the Administration provide to Congress that the States will maintain these categorical programs as identifiable activities after block granting?

Answer: We cannot assure State continuation of categorical activities after block granting; however, the Administration is firmly convinced that States will manage their programs as efficiently and effectively as programs administered at the Federal level. In our contacts with them, States have evidenced full understanding of their responsibility with the acceptance of the block grant, to assess needs throughout their jurisdictions and to allocate resources consistent with those needs according to priorities which they determine.

Question: What percentage of the Department's employees previously involved in administering the Migrant Health, Family Planning and Black Lung categorical programs will be retained to help administer the expanded Primary Care Block Grant?

Answer: Approximately twenty-five percent or 101 of the 375 positions previously involved in administering the categorical Primary Care program will be retained in 1983--81 are associated with phasing out the existing categorical programs and 20 are to administer the expanded Primary Care Block Grant.

PUBLIC HEALTH SERVICE HOSPITALS

Question: In the current fiscal year, Congress provides $146 million for transferring the eight Public Health Service Hospitals to local or other sponsors. Where do matters regarding these facilities presently stand?

Answer: All of the Public Health Service hospitals and clinics have been closed as PHS facilities. Five of the hospitals--Boston, Baltimore, Seattle, Staten Island, and Nassau Bay--and five of the clinics were converted to community-based organizations. In addition, three hospitals, San Francisco, Norfolk, and New Orleans, and two clinics, Honolulu and St. Louis, were taken over by either other Federal or State entities.

Question: Mr. Secretary, can you tell us your position on the proposed legislation developed by Senator Tsongas to transfer the remaining property at the former Boston PHS hospital to a community group interested in developing a housing project?

Answer: In September 1981, when the Department was accepting applications for transfer of the PHS hospitals under the Omnibus Budget Reconciliation Act, two nonprofit private community organizations in Boston, the Allston-Brighton Aid and Health Group and the Allston-Brighton Community Development Corporation, submitted a joint proposal to use the facilities of the Boston PHS hospital for combined health services and housing activities. They represented to us that a mixed use proposal of this kind would respond to the needs of the Boston community. We accepted that proposal as reasonable and consistent with the policy of local decision making. Nevertheless, the Act only authorized us to approve transfer of the hospital if it would continue to serve as a health care facility. Accordingly, the Department transferred only that portion of the Boston facility that would meet that condition, and only to the Health Group, which was responsible for the health care aspects of the mixed use proposal. Senator Tsongas's amendment would authorize transfer of the remaining portion for housing purposes to the Community Development Corporation, which was the organization responsible for the housing portion of the mixed use proposal. We have neither supported nor opposed the Senator's amendment. The Department has no experience in donating property for community housing or in monitoring the use of property for community housing after any such donation. Because it would be beyond the scope of the Department's programmatic interests or competence, we have not advocated a transfer of the remaining portion of the property for use as a community housing facility along the lines of the mixed use proposal.

Question: Should not the Senate Labor and Human Resources Committee have the opportunity to consider any legislative proposal that would empower you to make the transfer contained in the joint proposal to which you refer?

Answer: That Committee might well wish to address itself to many of the property disposal and other questions surrounding such a legislative proposal.

Response for the Record

In fiscal year 1982, States are eligible to apply for six of the seven block grants in the Department of Health and Human Services. (The Primary Care Block Grant does not take effect until October 1, 1982.) By the beginning of the third quarter, almost all States were participating in all of the block grants. Specific data is as follows:

Block Grant	# of States	# of Indians Tribes	Awards 3/31/82 (millions)
o Social Services	50	none authorized	$1,199.1
o Community Services	40	35	$ 111.9
o Alcohol, Drug Abuse and Mental Health	49	5	$ 193.0
o Maternal and Child Health Services	48	none authorized	$ 127.5
o Preventive Health and Health Services	48	2	$ 40.6
o Low Income Home Energy Assistance	50	117	$1,871.6

Question: In all of the Administration's pro-competition proposals, I have never heard serious consideration being given to developing competition between the professions. For example, allowing the nurse-midwives to effectively compete with the OB/GYN physician, the optometrists to compete with the ophtalmologist, the psychologist to compete with the psychiatrist, etc. Has this possibility been given serious consideration?

Answer: The Administration, in considering pro-competition proposals, is concerned with promoting effective and lower-cost ways of delivering high quality medical care. We recognize that some important innovations may involve the appropriate use of non-physician professionals, and we expect that improved market forces would lead health plans and patients to seek the services of the most cost-effective providers.

Some proposals designed to promote the use of non-physician professionals seek only for insurers and government programs to reimburse those professionals on the same basis as physicians. This risks merely adding more costs to the system, however. What is necessary in addition are incentives for plans and patients to consider costs along along with quality and therefore substitute lower-cost alternatives when appropriate.

Attached is a copy of the proposals the Department of Health and Human Services submittted to the Cabinet Council on Human Resources in December, 1981. We must emphasize that these proposals are still under consideration within the Administration and no final decisions have been made. Neither these nor any other proposals, therefore, represent official Administration positions.

Background

Health expenditures grew at an average annual rate of 12.5 percent between 1965 and 1980, a rate one-third higher than the annual growth in GNP during those same years. As a result, health expenditures rose from 6.0 percent of GNP in 1965 to 9.4 percent in 1980. Furthermore, the rate of growth seems to be increasing: in 1981 hospital expenditures have been increasing at an annual rate of 19 percent. Helping to fuel this long-term growth in health care costs has been an expansion of public and private health insurance coverage. About 90 percent of the population is now covered by health insurance of some kind.

Because of this extraordinary economic commitment, significant progress has been made in improving access to medical care. The percentage of low income people who had not seen a physician during the preceding two years declined from 28.2 percent in 1964 to 14.3 percent in 1978. By 1978, the average low income person made more than five visits per year to his physician, roughly the average for all citizens. Similarly, the percentage of non-poor elderly who had not seen a physician in two years declined from 18.7 percent in 1964 to 12.8 percent in 1978.

Increases in health care expenditures -- even increases above the rate of growth in GNP -- are welcome when they finance needed care, particularly for the poor and elderly. In effect, increased health care spending is a measure of our success in developing medical technology and distributing its benefits to all Americans. There is growing evidence, however, that the nation's investment in medicine is not being managed efficiently and that opportunities for still larger improvements in the public health and welfare are being missed. Experience at the Mayo Clinic, for instance, suggests that the nation's hospitalization rate could be reduced up to 30 to 40 percent without undermining quality. Similar reductions in hospitalization have been achieved by well established health maintenance organizations (HMOs). Since hospital costs are about 40 percent of all health care costs, reduced hospitalization could mean lower health care costs for private health plans and for Medicare and Medicaid.

Because health care spending looms so large in the Federal budget and in the economy in general, improving the efficiency of the health care system is a high priority of the Department of Health and Human Services. Soaring health care costs drive up the budgets of Federal and State health programs -- especially Medicare and Medicaid -- and fuel the general rate of inflation. In FY 1981, for example, Federal spending on Medicare and Medicaid alone was about $66 billion, or 26 percent of the HHS budget and 9 percent of the full Federal budget. Existing demographic trends threaten to push the already high rate of growth in Medicare and Medicaid (about 18 percent per year over the last decade) still higher. Unless the health care system becomes more efficient, then, Medicare and Medicaid will consume an ever-expanding share of Federal and State budgets.

The first step in addressing the ills of the health care system is to recognize that no group can be singled out for responsibility. Consumers, physicians, hospitals, and insurers all respond to the incentives that are now embedded in the health care financing system and in the government's tax and spending policies. Those incentives tell patients, providers, and insurers that more health care is better and that money is no object. The inevitable result is waste and inefficiency that can be eliminated without adversely affecting the health of the American people.

During the 1970s, Federal and State governments sought to use regulation to reduce inefficiency in the health care system. The hope was that the "health cost problem" could be solved by imposing controls on health care providers, while the government continued tax and spending policies that stimulated consumer demand for more medical care. Careful analysis has shown, however, that the assorted regulatory measures had little, if any, effect on rising costs and that, in some cases, they may have driven costs still higher. In short, clamping regulatory controls on an overheated health care system is just as futile as putting a lid on a pot that is boiling over. The more prudent course in each case is to turn down the fire under the pot.

In health policy, "turning down the fire" means redesigning the current tax policies and health programs that promote public and private insurance with few, if any, controls on costs. Absent such a change, we will see continued growth of first dollar, comprehensive insurance coverage that removes any incentive for patients or health care providers to be cost-conscious. That is not to say that coverage without effective cost controls ought to be excluded from the market; but the government should not promote such coverage at the expense of other types, including plans with significant deductibles and coinsurance or "alternative delivery systems" such as HMOs. Until the existing bias toward open-ended coverage is redressed, health care costs will continue to climb, forcing painful decisions not only regarding governmental budgets, but household budgets as well. All too often spending on food, education, and housing will be squeezed out, even though such spending contributes materially to preserving good health.

In keeping with the Administration's overall philosophy, HHS has abandoned the futile search for a regulatory panacea and is now looking for alternatives that get at the root cause of the health cost problem. The following options would make consumers, physicians, hospitals, and insurers more sensitive to the cost of medical care and allow them the latitude to adjust their behavior accordingly. In short, these proposals outline initial steps toward a "market" or "competitive" solution to the health cost issue. As such, these options complement the Department's phased withdrawal from regulatory programs like health planning.

The options now under review have been drawn from legislative proposals now pending before Congress, including bills sponsored by Senators Hatch and Durenberger and Congressmen Gephardt and James Jones. While serving in Congress, Secretary Schweiker and OMB Director Stockman were sponsors of earlier versions of the Hatch and Gephardt bills, respectively.

Options

Following are five options for improving the efficiency of the health care system. The options are grouped under two headings, "Private Sector" and "Public Sector". The options grouped under "Private Sector" deal with employment-based insurance. The "Public Sector" options are designed to improve Medicare. The budget estimates assume that the options are implemented in FY 1983.

Private Sector. Unlike cash wages, an employer's contribution to an employee health plan is not taxable income to the employee. The employer may, however, deduct the contribution from its taxable income. This preferential tax treatment for health insurance premiums encourages comprehensive, employment-based insurance with few, if any, controls designed to hold down the cost of medical care. In addition, this tax preference drains the Treasury and the Social Security Trust Funds of tax revenue. CBO estimates that in FY 1982, the tax preference for employer-paid health benefits will reduce Federal income tax revenues by about $20 billion and Social Security tax revenues by about $8 billion.

The three options that follow are designed to limit or offset the tax law's distorting effect on the demand for private insurance.

Option 1: Prohibit employers from deducting excessive health insurance premiums.

- Employers would not be permitted to deduct as a business expense health plan contributions exceeding $150 per month per employee with family coverage and $60 per month for individual coverage.
- The $150/$60 limit would be indexed so that it would increase at the same rate as the medical care component of the CPI (the MCPI).
- Firms that currently have health plan contributions higher than the $150/$60 limit would be "grandfathered" -- that is, they could continue to deduct their full base year contribution. However, future increases in their contribution would not be deductible until the indexed premium limit rises above their contribution.

- Because of the grandfathering provision and the time required for implementation, this proposal would have a minimal effect on FY 1983 tax revenues. In FY 1984, it would increase revenues by about $1.3 billion. By FY 1986, it would increase tax revenues about $3.0 billion.

Option 2: Encourage employers to offer a choice of cost-effective health plans, while giving employees an incentive to enroll in such plans.

- Tax credits would be granted to employers who offer their employees a choice of health plans. The credits would equal some fraction of the employer's start-up costs in moving from a single plan to a multiple plan arrangement. (For example, the credit might be equal to one-half of the employer's start-up costs, up to a maximum of $250,000 per firm.)

- To qualify for the credit, employers would be required to offer a plan with at least 20 percent coinsurance on all services (except specified preventive services) and, where available, a health maintenance organization (HMO). Additional options could also be offered. To assure that workers have adequate protection against the costs of catastrophic illness, all plans would be required to limit a family's exposure to out-of-pocket costs to no more than $3500 per year (indexed to increase with the MCPI).

- Where an employer offers a choice of plans, the employer must make the same premium contribution to whatever plan the employee chooses. Employees enrolling in a health plan that costs less than the employer's contribution would be entitled to a tax-free cash rebate. To reduce adverse selection against the comprehensive plans, the tax-free rebate would be limited to some percentage of the difference between the "whole group" premium of the high option and the premium of the plan actually selected, up to a maximum of $50 per month per family or $20 per month per individual. The $50/$20 limit on the rebate would be indexed by the MCPI.

- If the employer wants to offer a tax-free rebate larger than this limit, it may justify a larger rebate by showing that the increase is necessary to compensate higher risk employees for enrolling in a less expensive plan.

- Because it would take employers and the government time to implement this proposal, the tax credits and tax exemptions for cash rebates would have only a small effect on Federal tax revenues in FY 1983 and 1984. In FY 1986, this option would reduce tax revenues by about $200 million.

Option 3: Combine Option 2 with increased excise taxes on alcohol and cigarettes.

- A portion of the increased tax revenue from higher excise taxes would be set aside to offset the tax revenue loss from the tax credits and tax-free rebates in Option 2. Since FY 1981 revenues from the taxes on alcohol and cigarettes exceeded $8 billion, a small excise tax increase would cover the revenue loss from Option 2.

- The excise taxes for alcohol and cigarettes are fixed dollar amounts per unit. The taxes on distilled spirits ($10.50/gallon), wine (17c/gallon), and cigarettes (8c/pack) have not increased since 1951, even though the CPI has increased 238 percent in the interim. The tax on beer ($3.40/barrel) has not increased since 1964. The CPI has increased 183 percent since 1964.

Public Sector. Under Medicare Part A (hospital insurance), most patient cost-sharing is imposed late in a spell-of-illness (after the 60th day) when the patient can least afford it and when it is least likely to influence physician and patient behavior. Nor is there a limit under Part A on the out-of-pocket cost a seriously ill patient can incur. In addition, Medicare's rules for paying HM`Os discourage Medicare beneficiaries from enrolling in such plans. Under current law, conventional insurers cannot enroll Medicare beneficiaries, except for "Medigap" coverage paid for by the beneficiaries themselves.

Option 4: Combine improved incentives for Medicare beneficiaries with added coverage for catastrophic illness.

- One possibility would be to combine 10 percent coinsurance on all hospital days after the first day with a $2500 per year limit on beneficiary cost-sharing under Parts A (hospital insurance) and B (supplementary medical insurance). The existing limits on the number of covered hospital days (90 days per spell of illness and 60 lifetime reserve days) would also be eliminated. The $2500 limit on cost-sharing would be indexed to increase with the rise in the MCPI. This proposal would reduce Medicare outlays by $500 million in FY 1983 and by $950 million in FY 1984.

- An alternative package would combine 10 percent coinsurance on hospital days after the first with a $1,000 per year limit on beneficiary cost-sharing under Part A. There would be no limit on Part B cost-sharing. As under the immediately preceding proposal, the existing limits on the number of covered hospital days would be eliminated, and the $1,000 cost-sharing limit would be indexed to increase with the rise in hospital prices. This proposal would reduce Medicare outlays by $640 million in FY 1983 and by $1.0 billion in FY 1984.

Option 5: Offer Medicare beneficiaries the option of enrolling in private health plans.

- The Federal government would offer to pay 95 percent of Medicare's adjusted average per capita cost (AAPCC) on behalf of an aged or disabled beneficiary enrolling in a private plan. (Paying 95 percent of AAPCC, instead of 100 percent, provides the government some protection against cost-increasing adverse selection.) The beneficiary would pay the difference, if any, between the government's contribution and the plan's premium. Enrollment in a private health plan would be optional, and all beneficiaries would retain the right to return to Medicare during an annual open enrollment period.
- Both HMOs and conventional insurers would be eligible to participate in this "voucher" system. To qualify, a plan would be required to offer benefits at least as comprehensive as Medicare's Part A and B benefits. Plans would also be free to offer added benefits as a way of attracting enrollees.
- The amount of the government's contribution toward a private plan would be recalculated each year so as to reflect increases in the cost of the Medicare program.
- This option would have little impact on Medicare outlays in FY 1983 and FY 1984.

Smoking and Health

Question: What is the Department's position on the hazards of cigarette smoking?

Answer: In July 1957, the Surgeon General issued the Public Health Service's first statement on smoking and health: it identified cigarette smoking as a cause of lung cancer. Each of the succeeding Surgeons General has issued additional and stronger health warnings which have linked smoking with lung cancer and other cancers, heart disease, chronic lung disease, and adverse effects on pregnancy. The present Surgeon General, in issuing the 1982 report on the health consequences of smoking, again made clear the Department's position that cigarette smoking is the chief, preventable cause of death in our society and the most important health issue of our time.

Question: Is the Administration backing away from the Surgeon General's strong statement regarding the harmful effects of cigarette smoking?

Answer: The Surgeon General's published statement, released in the 1982 report, continues to be the Administration's position on the hazards of cigarette smoking.

HEALTH PROMOTION

The Health Promotion activities are intended to develop, implement and coordinate programs designed to prevent disease and disability through the enhancement of individual perspectives about disease prevention. The FY 83 budget request for health promotion activities is $2,326,000, an increase of $1,179,000 over the Fiscal 1982 level of $1,147,000.

Question: Why is the Department requesting twice as much money for Fiscal Year 1983 as was available for Fiscal Year 1982?

Answer: Health promotion is among the Department's highest health priorities. The request restores funding to the 1981 level for a solid health promotion program. This will allow the Department to sponsor the following activities:

- Continuation of cooperative agreements with approximately 3,000 local chapters of the Red Cross, YMCA, Urban League, Hispanic and other voluntary organizations;
- Formation of cooperative agreements with the Chamber of Commerce, to expand work-site programs; the Association of Chief State School Officers, to expand the emphasis on school health education; and the Advertising Council, to sponsor a continuation of the National Health Promotion Media Campaign.
- Work with the Business Roundtable to increase health promotion efforts at the worksite;
- Coordinate efforts with the Governors' Association on School Health Curricula;
- Operation of the National Health Information Clearinghouse;
- Implementation of national measurable objectives in prevention;
- Provision of technical assistance to public and private sector on health promotion efforts.

Question: What are the specific goals that you want to accomplish with your health promotion activities in Fiscal 1983?

Answer: Specific goals for 1983 include:

- Completion of the operational plans for the National Health Promotion Training Network which utilizes the resources of 3,000 local chapters of the Red Cross, the YMCA, the Urban League and the Coalition of Hispanic Health and Mental Health Organizations.

- The formation of a cooperative agreement with the Chamber of Commerce to expand the number of worksite-based health promotion programs for employees.

- The formation of a cooperative agreement with the Association of Chief State School Officers to expand the emphasis on school health education in the program of our Nation's school districts.

- The formation of a cooperative agreement with the Advertising Council to sponsor a continuation of the National Health Promotion Media Campaign.

Question: Will there be any new initiatives in health promotion in Fiscal 1983 that the Department has not attempted in the past?

Answer: While the overall focus will remain the same -- enhancing the awareness of controllable health risks among the general population--the Department will continue to try to find new avenues of reaching its goals. Consequently, new cooperative agreements will be effected with the Advertising Council, the Chief State School Officers, and the Chamber of Commerce. Furthermore, we will be working to facilitate access to health information within the Department by exploring and possibly developing a common access point through the umbrella of the National Health Information Clearinghouse.

HEALTH GOALS

According to your budget justification, the Public Health Service has made "significant progress" toward accomplishment of several national health goals.

Question: Specifically, what are the Administration's public health goals?

Answer: The Administration has established health priorities that fall into three broad categories. These are:

1. Maintaining the Nation's preeminence in health research,

2. Strengthening our efforts in the areas of disease prevention and health promotion, and

3. Redefining the appropriate Federal health role.

In the area of health research, our goal is to maintain a strong Federal commitment to biomedical and behavioral research. The results of such research clearly form the basis of all medical practice. Our many achievements in improved diagnosis and treatment are well known. But we still have much to learn about cancer, heart disease, diabetes, cystic fibrosis, and arthritis to name a few of many stubborn disease conditions.

At the same time, we are becoming increasingly aware of the need for greater research efforts in prevention--that is, developing ways to prevent disease and behavioral disorders. Prevention of disease and disability and the promotion of health is a major tenet of this Administration's health objectives and goals. Our best opportunities for significantly improving the Nation's health lie in the prevention of disease and the promotion of good healthy lifestyle practices. It is clear that this cannot be achieved simply through greater Federal health expenditures. Though the Federal Government can play a positive role in the area of prevention, a major reorientation of thinking and a national commitment to efforts designed to prevent diseases and promote health is needed. The rewards of such an effort can be great.

We are engaged in a thorough review and reappraisal of the Federal role in health. The Administration's goal to redefine the Federal health role is reflected in the transfer of responsibility from the Federal Government to States for health services delivery programs through the block grant concept.

Question: What accomplishments can you report for each of the objectives thus far?

Answer: The last several years have been an extraordinary period of scientific opportunity and advancement in biomedical research. Some examples of these achievements follow:

Immunology and Virology: The emergence of powerful recombinant DNA and hybridoma (cell fusion) technologies, coupled with an increased understanding of the immune system, now permits radically different approaches to the many still unresolved problems of immunology. Important advances have been made.

- During the past year, clinical trials, some of which were conducted by NIH, demonstrated the efficacy and safety of a hepatitis B vaccine. The vaccine has now been licensed by the Food and Drug Administration. Immunization programs based on this success may ultimately not only reduce the incidence of acute hepatitis B, but may also reduce morbidity and mortality from chronic active hepatitis, cirrhosis of the liver, and cancer of the liver.

- Investigators have developed a convenient, low-cost test to screen newborns for cytomegalovirus (CMV). This virus is frequently transmitted to infants at or near the time of delivery and is believed to be a leading cause of hearing impairment. It is also a cause of serious infection following kidney transplantation.

- Hybridoma research is being exploited to permit the detection of cancer at a very early stage by allowing scientists to label cancer cells in the body. The high specificity of the monoclonal antibodies produced by hybridoma techniques may lead to the killing of cancer cells by means of chemotherapeutic agents attached to the antibodies that specifically seek out and bind to cancer cells.

- In vision research, scientists have shown that some cases of uveitis (inflammation of the inner eye) may be triggered by exposure of the immune system to a certain enzyme protein present in all normal eyes. Investigators have now tested various drug treatments in animals and found that cyclosporin A, a drug currently used to prevent transplant rejection, can prevent the disease in laboratory animals.

Genetics and Gene Regulation: Recent discoveries have increased our understanding of the way genetic information is encoded and transmitted. Researchers are beginning to identify the fundamental defects in specific genetic diseases and to search for methods to repair them.

- One exciting research advance concerns transposable genetic elements. New knowledge has been gained regarding the ability of portions of chromosomes to rearrange themselves. It is this process that is responsible for the diversity of antibodies. Another area of accomplishment is that of genetic regulation--the processes by which cells control the production of cell components. An important recent development has been the discovery that cell transformation in vitro by retroviruses is frequently due to activation of one or two normal genes of a normal cell by the virus. Transformation in vitro is generally considered to be similar to the change from normal cells to malignant or cancerous cells. Retroviruses are relatively common RNA viruses found throughout nature.

- Knowledge of how environmental chemicals influence the mobile elements of DNA to determine the expression of damage, mutation, and heritable disease is advancing rapidly. A major initiative is aimed at improving short-term tests that measure the genetic and cellular changes thought to be precursors of carcinogenesis.

Noninvasive Diagnostic Techniques:

- Positron emission transaxial tomography (PETT)--a computer assisted imaging technique that enables visual mapping of metabolic processes of the brain--is now being applied experimentally to the fields of psychiatry, neurology, and gerontology. Current and potential uses include studies of schizophrenic patients, and the study of electroshock therapy, Alzheimers disease and epilepsy.

- An even newer, and potentially safer, noninvasive imaging technique, utilizing the principle of nuclear magnetic resonance, is being developed in the NIH intramural program.

Receptor Site Defects: Researchers have recently postulated a unifying concept for explaining the mode of action of a wide range of biologically active substances. Receptor sites on cell membranes are seen as "locks" into which a bio-active "key" fits in a highly specific manner to initiate a response.

- As part of this research, scientists have learned that the development of diabetes in certain patients appears to be due to a deficiency in the "insulin receptor" which enables the body to respond to the insulin by lowering blood sugar level. Similar deficiencies have been noted in other diseases as well, including myasthenia gravis and disorders in calcium and bone metabolism caused by nonresponse to vitamin D.

- The receptor site concept has been especially fruitful in neurobiology including the study of endorphins--the body's own pain killers. This research is providing a fuller understanding of the mechanisms of brain function, the causes of drug abuse, and the treatment of pain.

Impressive accomplishments in the prevention of disease and disability have been made in recent years. In the control of infectious disease, smallpox has been eliminated worldwide; polio, diphtheria, pertussis and tetanus are virtually eliminated in this country; and we are on the verge of eliminating measles. The reported incidence rate for measles in the decade 1950-1959 was 336 cases per 100,000 persons. In 1981 that rate had dropped to slightly over 1 case per 100,000 persons, only 3,032 cases nationwide.

Progress is being made in many other prevention areas:

- The prevention of some types of cancer may be possible through administration of naturally occurring or synthetic organic chemicals that appear to promote or inhibit cancers. Through epidemiological and experimental research, these substances and their effects are being identified, dose responses determined, and plans considered for clinical trials. Diet and nutrition research is also part of this effort.

- A live attenuated varicella vaccine appears to have promise for prevention of the serious and often fatal infections that leukemic children develop when exposed to chickenpox.

- Antiviral drugs are now the best hope of preventing influenza A during epidemics and the recurrence of herpes virus infections in patients receiving immunosuppressive therapy.

- Work on the prevention of asthma and allergic disease, particularly those associated with occupations is progressing. Methods to induce blocking antibodies or tolerance to specific allergens appear promising, as does work with chemically modified allergens to improve immunotherapy.

- Clinical trials are under way to learn whether vitamin E therapy in premature infants will reduce the risk of retinal damage and blindness. Other work is directed at senile cataracts since it appears quite possible that these are due to long-term oxidative damage, possibly triggered by exposure to light in the environment. If so, methods of protection can be devised.

This Administration has continued and expanded ongoing activities aimed at the 15 leading preventive causes of mortality and morbidity. Following are four examples of new initiatives:

- First, we have already succeeded in developing quantifiable goals for our 1990 prevention objectives and for each goal we have assigned a single PHS agency with prime responsibility to develop a detailed plan for achieving that goal.

- Second, an NIH prevention unit has been established to coordinate activities and set priorities in prevention research.

- Third, the Food and Drug Administration has launched a sodium reduction initiative to encourage lower soduim intake as a hypertension control measure.

- Finally, in October 1981, the Department sponsored a national symposium on the status of prevention curricula in undergraduate medical education.

The third major health objective--the redefining of the appropriate Federal role in health--was largely accomplished with the enactment of the Omnibus Reconciliation Act of 1981, which consolidated most health services categorical programs into four block grants to the States, two of which are the Preventive Health and Health Services Block Grant and Alcohol and Drug Abuse and Mental Health Services Block Grant. The enabling legislation established fiscal year 1982 as a transition period for implementation of these block grants by the States. That is, the States can elect to initiate the administration of the consoldiated health programs at the beginning of any of the four quarters of FY 1982. By the start of the second quarter of FY 1982, 48 States and five of the eligible U.S. territories have been administering the Preventive Health and Health Services Block Grant, and 49 States and five territories have assumed responsibility for the Alcohol and Drug Abuse and Mental Health Services Block Grant.

In summary, we feel that significant progress has been made toward accomplishing priority health goals in research, disease prevention and health promotion, and in redefining appropriate Federal roles in health.

NATIONAL HEALTH SERVICE CORPS

Question: Mr. Secretary, the Committee is concerned about personnel ceilings which create instability in the assignment of National Health Service Corps professionals and cause instability in the rural areas they serve.

In particular, we are concerned about Departmental actions which prevent the NHSC from retaining valuable assignees already in service, as well as policies curtailing the acquisition of new volunteers.

What will be the federally supported field strength for the NHSC in September 1982? September 1983?

Answer: The National Health Service Corps federally salaried assignee level will be 2,115 in September 1982 and in September 1983. Also, the Private Practice Option will provide an additional 712 assignees in 1982 and 835 in 1983 to provide care for those in need of medical services.

NATIONAL HEALTH SERVICE CORPS SPECIAL RETENTION PAY

Question: Your budget requests elimination of the special retention--or bonus--pay for those fulfilling their obligation for service in the National Health Service Corps.

It appears that those in the obligated category--whether Commissioned Corps officers or General Schedule employees--would each lose about $9,000. What is the reason for this proposal?

Answer: Those individuals who serve in the National Health Service Corps have been the recipients of National Health Service Corps Scholarships to support their medical school training. They then become obligated to serve with the National Health Service

Corps in shortage areas. We feel that providing them special retention pay is not appropriate because they are obligated to serve.

Question: What will its effects be on morale and productivity of those losing the bonus?

Answer: The reduction will be applied across the board beginning in 1983 for those newly entering or renewing obligated service agreements in the Corps.

Question: To what extent would you be establishing two classes of personnel--volunteers who will be paid $46,774 per year, and those with a service obligation who will get only between $33,000 and $37,000 per year? Is such a "class system" good for the Corps?

Answer: The reason for the special retention provision was to retain career officers who did not have to serve obligated duty. These officers would continue to receive the special retention pay. An obligated individual serving in the National Health Service Corps would not receive the special retention pay beginning in 1983. Obligors have received free medical education and we believe this proposal is equitable.

RISK REDUCTION/HEALTH EDUCATION

Question: Risk Reduction and Health Education funds were folded into the Preventive Health and Health Services Block Grant which is in its first year of operation. Your FY 1983 budget requests $1.3 million for Risk Reduction and Health Education activities separate from the block grant. For what specific health areas and activities will these funds be used?

Answer: Grant funds for the Risk Reduction and Health Education program have been consolidated into the Preventive Health and Health Services Block Grant. However, the current developmental state of the science in this area forces public and private sponsors to continue to need CDC's established technical expertise for assistance in choosing and implementing effective risk reduction and health education strategies. Funds to support CDC's risk reduction program operations in FY 1982 were provided by the current Continuing Resolution under the Preventive Health block grant program support. Because we are proposing to manage this block grant out of the Office of the Assistant Secretary for Health (OASH) in FY 1983, we are making a separate request of $1.3 million in CDC to retain its expert staff.

These funds will be used to support the development of effective educational methods and to provide consultation and technical assistance to organizations wishing to implement new health education methods. CDC continues to work closely with the States that are carrying out health education programs with their block grants. States often seek consultation from CDC because they do not find it cost-effective to maintain permanent staff expertise in specialized areas that may be needed only in the design phases of their programs.

Specifically, four areas of health promotion are being emphasized in the 1983 request. One is Health Risk Appraisals, a very promising technique to allow individuals to identify their own major health risks. Based on an individual's responses to questions on his/her lifestyle, a computer identifies the specific healt habits in need of change to enhance life expectancy. Another is school health education, which is very important, since it becomes harder to reduce risks once personal behavior becomes ingrained in adulthood. Evaluation methods are also important. When resources are scarce, it becomes very important to direct them to the health education efforts that have the greatest effectiveness--but managers do not find these easy to measure. Finally, we will continue to help States adopt economical but valid surveillance systems to measure the level of these problems within the State-- for example, local-level surveys of the prevalence of overweight, lack of exercise, smoking and alcohol use, and other factors. This kind of data is needed by the States to set priorities and to compare their progress with data from national surveys.

Question: To what extent are States focusing Prevention Block dollars exclusively on direct disease prevention programs and on any health education/risk reduction efforts?

Answer: The programs supported by the categorical funds are scheduled for renewal in August and September. Consequently, we have not had an opportunity to observe what decisions States are going to make in the level of support for these programs.

Generally, the States are indicating they will be supportive of continuing the efforts underway.

NIOSH TRAINING

Question: In FY 1982, NIOSH training was funded at a level of $5.7 million even though there was no budget request. The Administration is requesting no funds again for training in FY 1983. Why are no training funds being requested in FY 1983?

Answer: Because of the need to reduce Federal spending, we have had to make difficult choices as to Federal spending priorities in the occupational safety and health field. We still believe that even in the absence of Federal support, current occupational safety and health training programs will continue.

Question: On what do you base your assumption that funding of training activities will come from State, local and private sources as stated in your budget justification?

Answer: Several of the NIOSH Educational Resource Centers (ERC's) will begin their second 5 years of operation on July 1, 1982. Some of these had individual training project grants before they became ERC's. These experienced Centers should be able to rely on continued support from within the university structure. They should also expect to elicit and receive support from the private and non-Federal public sectors who receive direct benefits from these institutions when they recruit and place the ERC graduates to meet their personnel demands and needs. Some indication of the private sectors' appreciation of their opportunity to more fully support educational programs is seen by the recent announcement by the American Industrial Hygiene Association who is making available $50,000 in donated funds for individual fellowships for trainees in graduate industrial hygiene programs. Donors include private individuals who are practicing professionals in industry et al as well as large corporations and smaller companies. The funding structure of this "Fellowship Fundation" is designed on a long-term supportive base utilizing accrued interest/dividends only for the fellowship grants.

HERPES

Question: A subject we've heard quite a bit about lately is genital herpes. A recent New York Times article reported that between five and twenty million Americans are believed to suffer from herpes, a highly contagious, recurrent and incurable condition. Last week Newsweek Magazine reported that "the incidence of cervical cancer is four times higher among women with herpes than it is among those free of the disease." In light of the severity of this illness and lack of adequate treatment, why is this administration proposing to reduce funding for herpes control activities?

Answer: Although a reduction in funding for some herpes activities is being proposed, the Administration is increasing funds available for research directed toward the development of effective and safe therapies and vaccines for herpes (HSV). Expanded resources support NIH sponsored studies of the genetic material of this very complex virus. These studies, together with the knowledge of specific genes, are the foundation for the eventual design of new attenuated HSV that can be considered safe for live vaccines and for targeting of antiviral compounds for treating herpes infection.

Question: How much are you proposing to cut?

Answer: A total of $1.7 million is proposed to be cut from the direct operations budget of CDC for Fiscal Year 1983. About $900,000 of this amount is related to herpes studies.

Question: What activities would be eliminated?

Answer: This cut in resources will cause a reduction in ongoing and planned herpes activities including the implementation of a national surveillance system for congenital herpes, studies designed to evaluate the transmission of herpes among sexual partners, evaluation of preventive educational strategies for herpes, and epidemiologic collaboration with NIH multi-centered projects.

TREATMENT RESISTANT VD

Question: A new problem which seems to be of great concern particularly in large cities and on the West Coast, is penicillin resistant gonorrhea. How serious is this problem?

Answer: Since their recognition in March of 1976, a total of 4,743 cases of PPNG have been reported from 48 States, Guam, and the District of Columbia. From January to December of 1981 alone, there were 2,728 cases reported; a 144.4 percent increase from the same period of 1980. This continuing trend is due to both increases in disease importation and sustained domestic transmission in major metropolitan areas. Although PPNG infections constitute only 0.25 percent of all gonorrhea cases in the United States, disease importation and subsequent transmission within the United States can be expected to continue.

Question: What is CDC doing to try to develop successful treatments of penicillin-resistant gonorrhea?

Answer: In addition to monitoring the resistance of gonococcal strains to penicillin and other recommended therapeutic drugs, CDC supported research sites are continuing to participate with private pharmaceutical companies in trials of alternate therapies, predominantly cephalosporins, for the treatment of penicillin-resistant gonorrhea.

Question: What kinds of resources does the Administration plan to target on treating this strain of gonorrhea?

Answer: The Administration is committing both project grant and national leadership resources to the control of penicillin-resistant gonorrhea (PPNG). These resources are being focused on control efforts including: surveillance for PPNG by testing all gonococcal isolates for penicillinase production; timely identification and treatment of the sexual partners of all cases; screening of groups at high-risk for PPNG infection; and the use of spectinomycin for all patients who fail treatment with standard penicillin, ampicillin, amoxicillin, or tetracycline therapies for gonorrhea, patients who acquire gonorrhea in countries with high PPNG prevalence, and all PPNG cases and their contacts. Project grants in areas where outbreaks occur are supplemented and/or resources are shifted to curb these outbreaks and reduce spread to other cities or States.

CHILDHOOD IMMUNIZATION

Question: A recent New York Times editorial (March 31) stated that in 1983, under the proposed budget, 2.5 million less children would be immunized compared with the 1981 level. Is this an accurate statement? How many children will be immunized under the Federal Childhood Immunization Program in FY '83? To what extent are States using their health block grant funds to make up for any shortfall in the Federal Immunization Program?

Answer: The need for immunization in 1983 is based on the assumption that public sector programs will need to immunize half of the 10.8 million preschool-age children who need immunization during any year and that the backlog of school-age children requiring one or more immunizations will have been essentially eliminated by the end of 1982. This means that the number of children needing immunizations in the public sector drops from 8.3 million in 1981 to 7.8 million in 1982, and 5.4 million in 1983. This is also reflected in a decrease in the number of doses of vaccine required in the public sector from 28.3 million doses in 1981, to 26.4 million doses in 1982, to 24 millon doses in 1983.

The 1983 President's Budget includes immunization grant resources for the purchase of 9-10 million doses of vaccine or about 40 percent of the 24 million doses of vaccine required in the public sector in 1983. This proportion is comparable to that experienced in 1981. It is estimated that the 9-10 million doses will immunize 3.4 to 3.8 of the 5.4 million public sector children. The immunization program is being closely monitored in the Office of the Secretary as a part of the Operations Management System. At this time we cannot determine the extent to which States are using block grant funds for immunization activities.

RAPE PREVENTION AND SERVICES

Question: The Preventive Health Block Grant contains a provision of the law which sets aside $3 million to be allocated to the States for services to rape victims and for the prevention of rape. For what types of activities are the States using these funds?

Answer: No formal system is in place to gather this information. From the informal responses and inquiries received from grantees, we know that services are being provided through crisis centers for counseling victims in coping with stress, and dealing with the medical examination and legal issues. In addition, these centers often have hot lines for victims and near victims to seek help and support. State and local health departments are providing training for counselors, training for laboratory staff in evidence gathering, and training law enforcement agents.

Question: How many calls have been/are being received on the VD hotline about genital herpes? How many people are reporting herpes infection? What is the trend in VD hotline usage in general?

Answer: The VD National Hotline received 15,960 calls concerning genital herpes during their fiscal year, 1981. Almost one-fifth (19.6 percent) of all calls processed in 1981 dealt with herpes, more than for any other specific disease entity. Herpes calls for the first five months of fiscal year 1982 are running 50.2 percent above last year's monthly average. If herpes calls continue at the present rate, 23,976 calls will be received; more than one-fourth (27.4 percent) of all calls.

Overall call volume to the VD National Hotline has already increased. The 1981 total of 107,724 calls (including off-hour calls) was 22.5 percent higher than the figure for fiscal year 1980. The average monthly call volume for the first five months of fiscal year 1982 is 8.6 percent above last year's average. This projects to a total call volume of 117,084 calls for fiscal year 1982.

Question: To what extent are States not using Rape Prevention and Services funds for the purposes established in the law?

Answer: There is no evidence at this early stage of the Block Grant cycle to suggest that States are using the Rape Prevention and Services money for other than the intended purpose.

Question: What would happen to States which violate the law by not using the funds for Rape Prevention and Services Program?

Answer: States which are found to have diverted this Rape Prevention and Services for other purposes will be required to return that money to its intended use, or to the Federal government if the time permitted for program changes has elapsed. Should they refuse to do so, the statutes provide that the amount be withheld from future allotment to that State.

FLUORIDATION

Question: The Washington Post reported in January that tooth decay has been reduced by "an astounding one-third in American children in the past decade" and that is directly attributable to fluoridated water supplies and fluoride in toothpaste. It also stated that 59% of American children between the ages of 5 and 11 had never had a cavity, according to the latest survey of the National Institute for Dental Research. Now that it is included in the block grant, how will the fluoridation program fare?

Answer: Each State has flexibility under the Preventive Health and Health Services Block Grant to decide which preventive health programs they will continue, and the level of block grant funding which they will allocate to those programs. Project funding periods for categorical fluoridation grants actually extend into the current fiscal year, so it has not yet become clear what funding priority the States will assign to the program once the categorical funding has terminated.

Question: Do you expect any States to reduce significantly or eliminate their fluoridation activities without a categorical program?

Answer: Although the level of support the fluoridation program will receive in the other States is not certain at the present time, informal indications are that some two-thirds of the States which have been receiving categorical grant support will continue some level of support for fluoridation activities. Three States (Connecticut, Michigan, and New Jersey), that previously received categorical fluoridation grant funds, have indicated to the Centers for Disease Control that they will not continue to support fluoridation activities after the categorical funding period ends.

Question: Do you believe there is a need for continued Federal technical assistance in the area of fluoridation to continue to assist the States in developing their own programs?

Answer: For the past several years, the Centers for Disease Control (CDC) has provided direct technical assistance and consultation, when requested, to States and local communities to plan for and initiate community fluoridation programs. Assistance has also been provided in all engineering phases of fluoridation as well as in the development of monitoring/surveillance programs to ensure the maintenance of the optimal level of fluoride. Additionally, training programs for State health personnel have been provided which have developed their capacities to plan, initiate, and operate fluoridation programs. It is expected that as a result of this extensive technical assistance and the experience gained, State and local communities will apply this knowledge to plan and manage their respective fluoridation programs. Although no specific resources are requested for this purpose in 1983, the CDC will continue to provide technical assistance when requested, to the extent that resources permit.

PREVENTION

Question: With the possible exception of proposed increases in the "Smoking and Health" and "Health Promotion" programs within the Office of the Assistant Secretary for Health, it is difficult to determine why "prevention" does not appear to be woven into the fabric of programs throughout the Department, as I believe it should be, and as I expected to see this year considering some of your statements in the past. What is your comment?

Answer: Emphasizing prevention remains as one of my highest priorities and is essential to all of our health policies. Prevention helps both to control health care costs and to improve our nation's health status.

- o Because of its importance, I have recently ordered a Department-wide review of how to improve our prevention efforts.
  - -- An Executive Committee on Prevention has been established within the Department that I will personally chair.
  - -- I have issued a directive to all agencies in the Department to devote their resources to developing new activities or placing top priority on ongoing efforts in support of the theme of "Health Promotion".
- o An example of a successful prevention effort is the Department's initiative to eliminate measles transmission in the United States which has had dramatic success. The number of measles cases reported in 1981 were almost 80 percent lower (3,032 cases) than the number reported in the prior year, which had been the previous all-time record low year for measles cases.
- o We believe that much progress in preventive can be made by maintaining the traditional disease control efforts and by shifting gears in other areas, such as disease research and entitlement reimbursements, toward a greater prevention orientation.
  - -- In addition to funding research and demostration projects in HCFA which focus on prevention, the Medicare voucher proposal currently under development would permit beneficiaries to choose or health care plan which emphasizes preventive Health Care Services.
  - -- NIH wil continue to support research projects aimes at keeping people well and avoiding disease. Last October, we created a special office under the NIH Director to stimulate and coordinate NIH prevention research.
  - -- We are also requesting $1 million in HRA to stimulate new medical residency training programs in preventive medicine.
  - -- We have included $82 million for the Preventive Health Block Grant, to assist State prevention activities.

- In addition, it is important to educate people to be more responsible for their own health through lifestyle choices such as proper nutrition, moderate drinking, no smoking, and adequate exercise. These daily decisions influence people's health more than all of today's medicine.
  - \$1 million is requested in 1983 to maintain CDC staff expertise that assist public and private health education sponsors in choosing effective programs.
  - \$2 million is requested for the OASH Office of Health Promotion and Disease Prevention.
- There are numerous activities going on at present within the Department that will further our prevention efforts:
  - NIH has initiated a contract to test the safety and efficacy of a new chicken pox vaccine.
  - Departmental staff are participating in an international symposium to enhance strategies for world-wide measles eradication. Officials from the State Department, international health organizations, and vaccine manufacturers are also participants.
  - CDC staff presented to an American Educational Research Association symposium a report on how to measure effectiveness in programs that attempt to change lifestyle habits, e.g., smoking, alcohol, stress, obesity and exercise.
  - FDA is actively working with manufacturers, pharmacists, and senior citizen groups to improve ways to get information to patients on prescription drugs without requiring Patient Package Inserts.

CLINICAL TRAINING - REASON FOR TERMINATION

Question: The budget for fiscal year 1983 eliminates all funds for clinical training in the areas of mental health, drug abuse, and alcohol abuse. At the same time the report of the Graduate Medical Education National Advisory Committee indicates there will be a shortage of psychiatrists and other mental health care professionals over the next decade.

What effect will the elimination of clinical training have on the number of minority students pursuing careers in mental health?

Answer: We expect that the effect upon the number of minority students entering mental health careers will be minimal. Federal funds represent only a small portion of the cost of conducting these programs. Our main impact has been one of leverage upon the training community, rather than merely the production of trainees. While we are eliminating this program, a training capacity has been established at minority and other institutions which should be continued after termination of Federal funding.

GENERAL STATUS OF MENTAL HEALTH

Question: Can general conclusions be drawn about the trends in mental health in the U.S. over the last 10 years?

Answer: The nation's mental health profile appears to have been influenced most by demographics. We are becoming an older population, and a concomitant of that trend is an increasing number of people with senile dementia and Alzheimer's disease. At the same time, as the post World War II baby boom ages, we are seeing increased numbers of cases of schizophrenia. Another significant trend of the past ten years is the dramatic increase in the number of individuals who present themselves for treatment of mental health problems. In this respect, it is important to recognize that what may appear to be an increase in the incidence of mental illness is really an improvement in case finding and the accuracy of diagnosis.

FUTURE ADVANCES IN THE CURE OF MENTAL ILLNESS

Question: Which disorders have the greatest chance of being cured over the next ten years through additional research?

Answer: The most prevalent mental illnesses, the severe psychological depressions which afflict more than 9 million Americans each year, are also the mental illnessess which are the most responsive to available treatments. While drugs and psychotherapy may not always produce a cure, they are singly or in combination very effective in alleviating most symptoms and restoring the vast majority of patients to effective functioning in a brief period of time. Ongoing research is seeking even more effective treatments for this widespread psychological problem, and offers promise for the next decade.

The greatest promise of the next decade is not necessarily the cure of specific mental illness, although the area is certainly being actively researched. Rather, our greatest opportunity lies with improvement in the prevention, early identification, and more accurate diagnosis of specific subtypes of mental illness. We already have a variety of approaches which, with timely application, can greatly alleviate the debilitating symptoms of most mental illnesses. However, care givers are often frustrated by difficulties in matching specific subtypes of illness with appropriate treatments, as well as by the fact that they often are not given an opportunity to provide treatment until a mental health problem is well advanced. Recent discoveries of subtypes of various mental illnesses should produce more targeted treatment. In addition, recent advances in the use of techniques such as positron emission tomography and the matching of biological markers with certain illnesses should prove valuable as tools for earlier identification of problems which, when left unattended, become intractable in their later stages.

We are also hopeful that the next decade may see dramatic reductions in the incidence of undesirable side effects found with many of our current medications. Recent discoveries of psychotherapeutic substances produced naturally by the human body could be exploited to produce a new generation of medications which will prove more compatible with natural body chemistry.

INCIDENCE OF MENTAL DISORDERS

Question: Has the incidence of mental disorders been increasing or decreasing?

Answer: In terms of cases per 100 thousand population, there probably has been no significant change in the overall incidence of mental disorders. However, because of the changing composition of our population, numbers of persons needing care for specific age-related mental disorders tend to change. The National Institute of Mental Health is funding a long term series of epidemiologic studies which is expected to define these trends with some degree of accuracy. Based upon the increasing proportion of elderly persons in the U.S. population, we may infer, for example, that problems relating to senile dementia and depression are increasing.

NURSES ON ADVISORY COMMITTEES

Question: Your personal assistance in insuring that a greater proportion of the Alcohol, Drug Abuse, and Mental Health Administration's advisory committees will be professional nurses would be most appreciated. Currently, I understand that only 3 percent of these individuals are nurses, and most of them are on one committee--the Nurse Training Committee. It would seem that a goal of 20-25 percent would be reasonable.

Answer: I recognize that nurses can make valuable contributions to advisory committees of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), and share the interest in having increased participation of nurses on these groups. I understand from Dr. Mayer, the ADAMHA Administrator, that outreach efforts are being made through groups such as the American Nurses Association to identify nurse candidates for appropriate committees.

While we are committed to this approach, a goal of 20-25 percent nurse committee members is not realistic. Most of ADAMHA's advisory committees provide peer review of research grant applications, and there is only a very small number of nurse researchers in areas covered by these committees. A person must be considered a primary investigator in order to be considered qualified to conduct technical reviews of research applications.

ADVISORY COMMITTEE

Question: To what extent is your administration being responsive to the report language I had included urging a closer look at what types of mental health service, provided by which types of practitioners, should be reimbursed under Medicare and Medicaid? During your testimony before us last year you explained how an interdisciplinary alcohol advisory committee could assist you in sifting out the various issues within the alcoholism community. It would seem to me that such an interdisciplinary committee would be most helpful in resolving similar issues regarding mental health; i.e., what types of services are safe, effective and appropriate.

Answer: The Department is taking a close look at mental health services provided to Medicare beneficiaries by mental health professionals in organized care settings under the Medicare

Mental Health Demonstration. This project is jointly funded and managed by the Office of Planning and Evaluation, the Health Care Financing Administration and the Alcohol, Drug Abuse, and Mental Health Administration. The second of two years of reimbursement under waivered conditions has just begun. Medicare benefit limitations have been raised ($250 to $750) or removed; the facility rather than the professional provider is reimbursed; reimbursement is at reasonable cost rather than fee-for-service; and the services of clinical psychologists, psychiatric social workers and psychiatric nurses, or services they supervise, are covered under the demonstration, in addition to physicians' services. The study will evaluate the current impact of these demonstration factors on Medicare program costs and beneficiary utilization as well as the projected impact if the conditions were extended to all eligible organized providers of mental health care.

NIMH is very concerned with the question of which services are most safe, effective, and appropriate. At this time we feel that further research is needed to provide support for any decisions or recommendations in this area. The Institute plans to expand its research on clinical services and mental health service delivery, and also to obtain better data on the services actually provided by the different types of providers.

The National Advisory Mental Health Council, established by law, is by composition an interdisciplinary body, established to advise the Secretary on issues within the mental health community. Over the past two years the Council has given studied attention to issues involving the safety, effectiveness and appropriateness of mental health services, and continues to study these issues with particular attention to their interface with issues of reimbursement under both public and private financing programs.

The Department is also conducting a three year demonstration designed to test the cost-effectiveness of expanding Medicare and Medicaid coverage of alcoholism treatments in free-standing settings, as opposed to hospitalization. The project is being conducted in seven states involving 23,000 patients.

FUTURE OF CLINICAL TRAINING

Question: I am concerned that during the next fiscal year your Department may not recommend funds to continue the clinical training programs of the National Institute of Mental Health. I am especially concerned that we do not have sufficient minority mental health practitioners of all disciplines, especially psychiatric nursing and para-professionals. I would hope that you would reconsider this matter.

Answer: The decision to phaseout our clinical training represented a very difficult priority choice because shortages of personnel do exist in certain categories. However, faced with the necessity of reducing Federal spending, it was necessary to examine programs in terms of their relative ability to continue to function with non-Federal support. Such is the case with training, in which the Federal investment represented a relatively small share. We have been successful in using leverage on the training community to encourage the establishment of curricula in various scarce-category mental health fields, including some at minority institutions. We expect that State and private funds, as well as student fees and service reimbursement collections, will increase to make up all or a large part of the Federal share. For that reason, programs such as the training of minority mental health professionals, psychiatric nurses and para-professionals should be able to continue without Federal aid.

PARENTAL NOTIFICATION REGARDING DRUG TREATMENT

Question: Is there any plan to notify parents whose children receive drug treatment?

Answer: There are no plans to require drug abuse treatment programs receiving Federal funds through the Alcohol, Drug Abuse and Mental Health block grant to notify parents whose children receive drug abuse treatment. We believe this is an issue that should be decided by the States, since they administer the block grant funds and since current State policies vary. Some States require the consent of the parents of children under 18 before they will provide drug abuse treatment; other States have no such requirement.

PHASEOUT OF CLINICAL TRAINING

Question: What is the impact of zeroing out mental health clinical training? Will this result in a shortfall of psychiatrists and psychologists? What is the HHS position on the adequacy of the number of psychiatrists?

Answer: There appears to be no doubt that there is a shortage of psychiatrists. This is not presently the case with respect to psychologists, however, where the current supply appears to be adequate. We expect that the zeroing out of mental health clinical training will not significantly affect the supply of mental health personnel. The States currently devote a sizeable share of their budgets to their universities, and have a substantial interest in continuing those programs which are responsive to State and local needs. It is in their interest to make up the relatively smaller percentage of funds which were provided by the Federal government, unless the programs are deemed irrelevant to State requirements.

MEDICAID CO-PAYMENTS

Question: What mechanism are you proposing to insure that health care providers are able to collect co-payment fees? For example, should doctors turn away patients if they do not have the $1 or $1.50 co-payment fee?

Answer: Medicaid will use the same mechanism as Medicare used to collect these fees from the beneficiaries; that is, the providers will collect the fee from the beneficiary either at the time of service delivery, or subsequently through their normal billing process.

The dollar value of these fees is relatively nominal, so that most beneficiaries will be able to pay the fees at the time of delivery of the service.

Question: How do you respond to the concern that co-payment fees might reduce Medicaid utilization of physician services, but that in a number of cases, a patient might forego an early doctor visit and end up in the hospital with a more advanced, serious illness?

Answer: We are confident tha imposing reasonable cost sharing for certain Medicaid services will discourage inappropriate utilization and provide incentives for the use of cost-effective health services, while not deterring beneficiaries from seeking necessary care. The copayment requirements have deter needed care.

In the California co-payment experiment, which lasted over a year, approximately 30 percent of the State's Medicaid beneficiaries were required to share in paying for prescriptions and visits to health practitioners. Each month, $.50 for each of the first two prescriptions and $1.00 for each of the first two visits to health practitioners was required. As a result of the project, utilization rates were reduced up to 15 percent for some groups. Data showed that beneficiaries did not forego care for problems that they considered serious or for medical conditions judged significant by a physician panel.

MEDICAID ALTERNATIVE BUDGET

Question: The budget for the Medicaid program is predicated upon enactment, by July 1, 1982, of legislative changes designed to reduce the cost of the program by $1.883 billion in FY 83. To this Committee's knowledge, no committee in Congress has even begun a serious study of your proposals. Does the Department plan to submit an alternative budget after July 1 if no or few reforms have been enacted?

Answer: There are no plans at the present time to submit an alternative budget after July 1. It is our hope and expectation that Congress will act on the President's legislative program by that time.

PREVENTIVE CARE

Question: What bias do you believe it is possible to give the Medicaid and Medicare programs to try to encourage preventive medicine services?

Answer: Because of the nature of financing programs and certain statutory restrictions (particularly in Medicare), funding for services is primarily for treatment of illness or injury. However, there are a number of exceptions such as the child health screening programs, the optional prevention services covered under Medicaid, and comprehensive services provided by health maintenance organizations (HMOs) in both Medicare and Medicaid.

In addition to funding research and demonstration projects, some of which are now underway with others to begin in FY 1983, we will also conduct activities to enhance our service capabilities. For example, we hope to encourage greater Medicare enrollment in HMOs by including information about HMOs in our Medigap training sessions and through distribution of a new pamphlet explaining HMOs to beneficiaries in areas where HMOs are functioning. We are also preparing a Notice of Proposed Rulemaking for the child health program which will provide for the services of a continuing care provider - an HMO or other appropriate entity - that will provide health services and also assure referral of children to other sources for needed care.

We will also continue our review of current activities and programs to determine where greater emphasis can be placed on health promotion, taking into account cost of other barriers.

Question: In what way do any of the entitlement reforms you have proposed try to skew Federal reimbursement policy towards preventive medicine?

Answer: A Medicare voucher system which is currently under development would permit beneficiaries to choose a health care plan which emphasizes preventive health care services. We will also begin, in FY 1983, two demonstrations to study Medicare and Medicaid coverage of certain preventive health care services. The demonstrations will assess the short-term and long-term impact of health prevention and promotion activities on utilization and cost and on measures of health status.

LONG-TERM CARE COSTS

Question: What plans do you have to try to reduce or constrain burgeoning long term care costs?

Answer: The Administration is considering a number of alterntive solutions to the problem of the high cost of long-term care. Since most of our present long-term care programs are administered at the State level, we are primarily exploring solutions which will give States the flexibility they need to control costs. Some of these initiatives include:

+ Implementing section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) which permits States to request waivers to include in their Medicaid plans approved home or community-based services to individuals who would otherwise require care in SNFs or ICFs'; and

+ Conducting a series of projects to assess the effectiveness of channeling-type programs with regard to controlling long-term care costs.

In addition, the Secretary has established a Long-Term Care Task Force under the leadership to the Assistant Secretary for Planning and Evaluation to explore a broad range of policy issues related to Long-Term Care.

Question: Has the Administration considered a block grant approach for long-term care payments? What prospects do you see for such an approach?

Answer: Block grants for Medicaid long-term care services are but one of a number of options we are exploring as part of the New Federalism effort. However, at the present time, no final decisions have been made with regard to which option we will be pursuing.

Question: Several States use a prospective reimbursement payment system for long-term care. What success have these States had in holding down costs?

Answer: We have no evaluation data to compare the experience of prospective reimbursement vs. cost-based reimbursement for Medicaid long term care benefits. Most States already set Medicaid nursing home rates prospectively. We do know, however, that the average cost of Medicare long term care, which is cost-based, is higher than Medicaid long term care.

PROSPECTIVE PAYMENT SYSTEMS

There is a growing discussion that an effective means of constraining health care costs would be to move to a prospective reimbursement policy for the Federal health care programs. Under such a system, an institution would receive a fixed fee, at a rate set in advance, for a certain number and kind of medical services. Institutions can make a profit if they keep costs below the amount of their fees.

Question: Does the Administration have any plans to move to a prospective reimbursement system?

Answer: The Health Care Financing Administration is currently conducting a major review of options for establishing a prospective reimbursement system. Any decision to move foward with a specific proposal will depend on the results of that analysis.

Question: What do you believe the possible savings might be under a prospective system?

Answer: The budget impact of a prospective system depends upon its design, and could range from a cost to substantial savings.

Question: What drawbacks do you see to a prospective reimbursement system?

Answer: We are not aware of any major drawbacks to a prospective payment system.

NURSE-MIDWIFE REGULATIONS

Question: The Reconciliation Act of 1980 authorized Medicaid reimbursement for nurse-midwife services. Regulations to implement this provision have still not been enacted.

When will the Department publish these regulations?

Answer: Proposed interim final regulations were approved on April 22, 1982. They have been forwarded to OMB for review prior to publication in the Federal Register.

Question: Why have they been so slow in being published?

Answer: The delay has been due principally to the need to resolve questions concerning the required qualifications of a nurse-midwife. Various standards have been considered, including the use of national accrediting body certification standards and State-specified requirements. Review of this question necessitated some delay in development of the regulations. However, as noted above, we expect publication in the very near future.

Question: What, if any, cost savings do you estimate will accrue from implementation of these regulations?

Answer: The Department estimates a savings ranging from $2.2 million in FY 1983 to $2.8 million for FY 1985.

SKILLED NURSING FACILITIES

Question: Secretary Schweiker recently announced that he was calling off plans to revise health and safety rules for the 8500 skilled nursing facilities that get money from Medicaid and Medicare.

There are a set of related regulations that are still being considered involving inspections of nursing homes to see how they are complying with health, safety and other rules. Have you made any decisions on this set of regulations?

Answer: These regulations are still under review. No final decisions have been made at this time.

HOME HEALTH AND HOME CARE SERVICES

Question: On another subject--home health. You can't go anywhere outside of Washington without hearing from all older Americans what a high priority they put on expanding home health and home care services. Does this Administration plan any initiatives in the home care area? What is your position on S. 234, the bill which has been introduced in the Senate to expand Medicare reimbursement for home health services?

Answer: HHS recognizes the need to address the issue of long-term care, including home care services, for a steadily growing elderly population. A number of demonstrations currently are underway to help us in this effort. Among these are this Department's National Long-Term Care Demonstration Program, which is testing and will evaluate various approaches to coordinating a cost-efficient and humane long-term care policy.

We are also implementing the provision of the 1981 Omnibus Budget Reconciliation Act (P.L. 97-35) which permits the Secretary to grant waivers to States to provide home and community-based services for certain individuals under Medicaid. Regulations implementing this provision were published on October 1, 1981. To date we have received 25 waiver requests from 19 States. Requests from the States of Louisiana, Montana, Oregon, Kansas (partial) have already been approved.

We are also conducting demonstration projects for the training and employment of AFDC receipients as home health aides as authorized by the Omnibus Reconciliation Act of 1980 (P.L. 96-499). Seven States have been selected to participate in the demonstration--Arkansas, Kentucky, New Jersey, New York, Ohio, South Carolina, and Texas.

In addition, we are working to develop an experiment to provide prospective payment for home health agency services.

With respect to S. 234, we oppose this bill because of its high cost.

SWING BED REGULATIONS

Question: One last question. We have been waiting for your deparment to issue regulations on the swing bed program since July of last year. When do you expect these guidelines to be out?

Answer: These have been rather difficult regulations to develop; consequently, they have undergone extensive review and modification within the Health Care Financing Administration. I understand that submission to the Department is imminent. Once my staff clears them, the regulations will be forwarded to OMB for final approval. That should take four to six weeks.

NURSE-MIDWIFE REGULATIONS

Question: What is the status of the Medicaid nurse-midwife reimbursement regulations? These were a provision of the 1980 Budget Reconciliation Act, and I understand that all of the modifications of the 1981 Budget Reconciliation Act have now been published in the Federal Register.

Answer: I approved the proposed interim final regulations on April 22, 1982. The regulations have been forwarded to OMB for review prior to publication in the Federal Register; therefore, we expect publication in the very near future.

NIH BUDGET POLICY

Question: Mr. Secretary, you have always been a strong supporter of the NIH program and we're glad to note this year's proposed increase of $108.5 million in funding for biomedical research. However, there are some anomalies that trouble us and we hope you can help clear things up.

For example, the NIH budget abandons the concept of stability of new research grants by decreasing the number of these grants from 4,741 to 4,100. You also propose to put a 90% cap on indirect costs associated with research, reduce the average cost of non-competing continuation grants by 3 to 4 percent, and reduce training allowances to slightly below the fiscal 1982 level.

What can you tell us about your approach? If you don't put the $108.5 million money into new research where will it go?

Answer: We continue to believe that stabilization of the number of research project grants is a desirable goal. However, given the current policy of economic restraint inherent in the development of this year's budget, the goal of 5,000 new and competing grants as the level at which research should be stabilized is no longer a feasible one for 1983. Keep in mind, however, that NIH will be supporting over 15,000 grants in total in 1983 including continuations. By any estimate, this is a substantial effort. In formulating the 1983 budget for NIH, an effort was made to fund as many new research project grants as possible while maintaining the necessary balanced distribution of resources between research project grants and NIH's other research and research training mechanisms. This distribution of resources reflects the continued high priority NIH places on investigator-initiated research with almost 50% of the total resources requested in 1983 for NIH being devoted to research project grants. This is the same percentage of the total NIH resources as this mechanism received in both 1981 and in 1982 under the current continuing resolution.

The indirect cost proposal was developed in the context of our attempt to maximize the number of new and competing research project grants that could be supported and at the same time maintain a proper program balance among the research activities NIH supports. The proposed 10% reduction is viewed as an efficient and uncomplicated way to achieve budget economies in the immediate future and allow time for consideration of approaches that may be more suitable for long-term policy.

The 3 to 4% reduction in average costs was effected in 1982, again to maximize the number of new and competing research project grants that can be supported within available funds. These reductions do not apply to any specific award; the percent reduction will vary from award to award, but in the aggregate will average 3 to 4%. This reduction in direct cost for non-competing continuation grants, made in 1982, will be continued in 1983.

With regard to research training, the number of trainees that will be supported in 1983 reflects an allocation of training resources that will maintain a good program balance between many compelling research needs. I believe 8,900 trainees will constitute a reasonable research training pool which if not compressed for too many years should not compromise the supply of future investigators. The 1983 budget will continue the 1982 policy of providing for approximately 50% of the institutional allowances payable in 1981 and payment of 8% indirect costs.

Question: Mr. Secretary, what commitment base did you use to develop the FY 1983 NIH budget?

Answer: The 1982 September budget was used as the base in developing the 1983 budget for NIH.

NATIONAL EYE INSTITUTE

Question: The Department received $3 million in construction money in fiscal 1980, yet Dr. Kupfer, Director of the National Eye Institute, informed this Subcommittee that the Department is only now preparing to award the money. Why has it taken so long to make this money available?

Answer: In recognition of the fact that the NEI construction grant program was new and would require some time to establish, the Congress appropriated construction funds in FY 1980 but stipulated that those funds remain available until expended.

Several steps were necessary before the National Eye Institute could implement the new construction grant program. The process begain in November 1979 when the Institute, with the advice of the National Advisory Eye Council, developed guidelines concerning the use of these funds, the maximum size of the awards, and the requirements for matching funds. The guidelines were established and announcements describing the new program were prepared by March 1980. Since there was some uncertainty concerning the final 1980 budget level for NIH, the Institute did not receive approval to release the announcements until September 1980. At this time the NEI forwarded supplemental instructions for preparing these new construction grant applications through channels for administrative clearance. The Office of Management and Budget approved these instructions for release to the public in March 1981. The deadline for submitting the first round of construction grants applications was May 1981.

The actual time allotted for grant preparation was 9 months -- from September 1980 to May 1981. It was important to provide this amount of time for institutions to prepare their construction grant applications, which are generally more complicated than regular grant proposals. For example, a potential applicant must obtain program concept clearance from the institution, prepare preliminary architectural plans, and get other local clearances. The longer application time made it possible for institutions that were not currently involved in construction projects to prepare a competitive application for NEI funds. The initial peer review was completed in October 1981, and the National Advisory Eye Council made its recommendations for funding in February 1982.

Question: When will it finally be awarded?

Answer: I am happy to note that we have essentially adhered to the schedule which was submitted to you with the testimony on the 1983 appropriation. All the $3 million appropriated in 1980 has been committed. Five construction grant awards have been made, and the remaining four awards will be made as soon as the recipients submit final documentation of clearances needed from local authorities and their construction schedules.

NIH ACHIEVEMENTS

Question: Each year it has been the practice of NIH to review major achievements and breakthroughs in biomedical research. Please summarize major achievements and breakthroughs in NIH-sponsored biomedical research over the past year.

Answer: We have been witness to an extraordinary period of scientific opportunity and advancement in biomedical research. Some recent examples of these achievements follow:

Immunology and Virology: The emergence of powerful recombinant DNA and hybridoma (cell fusion) technologies, coupled with an increased understanding of the immune system, now permits radically different approaches to the many still unresolved problems of immunology. Among the important advances that have been made are the following:

- During the past year, clinical trials, some of which were conducted by NIH, demonstrated the efficacy and safety of a hepatitis B vaccine. The vaccine has now been licensed by the Food and Drug Administration. Immunization programs based on this success may ultimately not only reduce the incidence of acute hepatitis B, but also may reduce morbidity and mortality from chronic active hepatitis, cirrhosis of the liver, and cancer of the liver.

- Investigators have developed a convenient, low-cost test to screen newborns for cytomegalovirus (CMV). This virus is frequently transmitted to infants at or near the time of delivery and is believed to be a leading cause of hearing impairment. It is also a cause of serious infection following kidney transplantation.

- Hybridoma research is being exploited to permit the detection of cancer at a very early stage by allowing scientists to label cancer cells in the body. The high specificity of the monoclonal antibodies produced by hybridoma techniques may lead to the killing of cancer cells by means of chemotherapeutic agents attached to the antibodies that specifically seek out and bind to cancer cells.

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- In vision research, scientists have shown that some cases of uveitis (inflammation of the inner eye) may be triggered by exposure of the immune system to a certain enzyme protein present in all normal eyes. Investigators have now tested various drug treatments in animals and have found that cyclosporin A, a drug currently used to prevent transplant rejection, can prevent the disease in laboratory animals.

Genetics and Gene Regulation: Recent discoveries have increased our understanding of the way genetic information is encoded and transmitted. Researchers are beginning to identify the fundamental defects in specific genetic diseases and to search for methods to repair them.

- One exciting research advance concerns transposable genetic elements. New knowledge has been gained regarding the ability of portions of chromosomes to rearrange themselves. It is this process that is responsible for the diversity of antibodies. Another area of accomplishment is that of genetic regulation--the process by which cells control the production of cell components. An important recent development has been the discovery that cell transformation in vitro by retroviruses is frequently due to activation of one or two normal genes of a normal cell by the virus. Transformation in vitro is generally considered to be similar to the change from normal cells to malignant or cancerous cells. Retroviruses are relatively common RNA viruses found throughout nature.

- Knowledge of how environmental chemicals influence the mobile elements of DNA to determine the expression of damage, mutation, and heritable disease is advancing rapidly. A major initiative is aimed at improving short-term tests that measure the genetic and cellular changes thought to be precursors of carcinogenesis.

Noninvasive Diagnostic Techniques:

- Positron emission transaxial tomography (PETT)--a computer assisted imaging technique that enables visual mapping of metabolic processes of the brain--is now being applied experimentally to the fields of psychiatry, neurology, and gerontology. Current and potential uses include studies of schizophrenic patients, and the study of electroshock therapy, Alzheimer's disease and epilepsy.

- An even newer, and potentially safer, noninvasive imaging technique, utilizing the principle of nuclear magnetic resonance, is being developed in the NIH intramural program.

Receptor Site Defects: Researchers have recently postulated a unifying concept for explaining the mode of action of a wide range of biologically active substances. Receptor sites on cell membranes are seen as "locks" into which a bio-active "key" fits in a highly specific manner to initiate a response.

- As part of this research, scientists have learned that the development of diabetes in certain patients appears to be due to a deficiency in the "insulin receptors" which enable the body to respond to the insulin by lowering blood sugar level. Similar deficiencies have been noted in other diseases as well, including myasthenia gravis and disorders in calcium and bone metabolism caused by nonresponse to vitamin D.

- The receptor site concept has been especially fruitful in neurobiology including the study of endorphins--the body's own pain killers. This research is providing a fuller understanding of the mechanisms of brain function, the causes of drug abuse, and the treatment of pain.

Prevention: Disease prevention continued to receive special attention in our planning and allocation of resources. In 1981 well over one-half billion dollars was spent on research directly related to prevention. Notable past successes have been achieved by strategies built on knowledge and technology provided by NIH research -- the high blood pressure control program and other programs to reduce the risk of heart attack and stroke being examples. The National Toxicology Program is another example of an outstanding prevention activity. Progress is being made in many other areas, including the following:

- The prevention of some types of cancer may be possible through administration of naturally occurring or synthetic organic chemicals that appear to promote or inhibit cancers. Through epidemiological and experimental research, these substances and their effects are being identified, dose responses determined, and plans considered for clinical trials. Diet and nutrition research is also part of this effort.

- A recent survey has shown that the prevalence of dental caries is about 30 percent lower than it was at the time of a 1971 survey. This reduction is attributed in large part to more widespread availability and use of fluorides, a longstanding initiative of the NIH.

- Progress is being made on vaccines other than hapatitis B. A live attenuated varicella vaccine appears to have promise for prevention of the serious and often fatal infections that leukemic children develop when exposed to chickenpox.

- Antiviral drugs are now the best hope of preventing influenza A during epidemics and the recurrence of herpesvirus infections in patients receiving immunosuppressive therapy.

- Work on the prevention of asthma and allergic diseases, particularly those associated with occupations, is progressing. Methods to induce blocking antibodies or tolerance to specific allergens appear promising, as does work with chemically modified allergens to improve immunotherapy.

- Clinical trials are underway to learn whether vitamin E therapy in premature infants will reduce the risk of retinal damage and blindness. Other work is directed at senile cataracts since it appears quite possible that these are due to long-term oxidative damage, possibly triggered by exposure to light in the environment. If so, methods of protection can be devised.

- Low density lipoprotein (LDL) is the major vehicle for transporting cholesterol in human blood plasma. The mechanism for degrading LDL has now been demonstrated in animals, and may eventually lead to clinical applications to control cholesterol levels in the blood stream and thus to contributing to the prevention of heart attack.

Question: What significant breakthroughs do you anticipate in the coming year?

Answer: New research initiatives emerge from the opportunities and promise created by significant discoveries. For example, the emergence of powerful recombinant DNA and hybridoma (cell fusion) technologies coupled with an increased understanding of the immune system now permits radically different approaches to the many still unresolved problems of immunization. The 1983 budget request addresses this and other significant opportunities such as genetic research, fetal surgery, and non-invasive imaging techniques, to mention but a few. Investigator-initiated research continues to represent the primary mechanism for discovery of such new opportunities. We are confident that, through the peer review system and NIH in-house scientific expertise, the most crucial research initiatives are properly identified and supported.

Question: Which programs in the NIH at large do you feel offer the greatest promise of breakthrough and therefore should be maintained at present or increased levels of funding?

Answer: Scientific breakthroughs are not easy to predict since research is essentially a continuing process of discovery in which today's assumptions or theories can be modified by tomorrow's findings. A number of areas of investigation, however, show promise for substantial contribution to biomedical knowledge or medical treatment and consequently deserve high priority. Examples of these promising areas include:

- Studies of the chemopreventive properties of retinoids (vitamin A - related compounds) in populations at high risk of cancer.

- Research into viruses associated with cancer. Last year a landmark discovery was made when a virus associated with leukemia was isolated. Now that the cause of this particular form of cancer is understood, much work can be done toward prevention.

- Heart and vascular disease. A new group of pharmacological agents, which block the passage of calcium across cell membranes, shows great promise for the control of abnormal heart rhythms, angina pectoris, and other coronary problems.

- Diabetes research. Recent developments, such as synthetic production of human insulin using recombinant DNA techniques and transplantation of the insulin-producing cells of the pancreas, have contributed much momentum to the study of this disease. Considerable potential exists for further advances in the day-to-day treatment of diabetes.

- Studies of the nervous system. As a result of recent findings in neurochemistry and neurobiology and the use of non-invasive imaging techniques, science is on the threshold of knowing how the nervous system functions as the master regulator and coordinator of most body functions. Such knowledge has significant implications for the prevention and treatment of neurological disorders.

- New vaccines utilizing recombinant DNA and hybridoma technologies, including a second generation hepatitis B vaccine, and vaccines for sexually transmitted diseases, infant diarrhea, dental caries, and bacterial meningitis.

- Genetic research, in which recent discoveries about the moveable segments of the DNA molecule show great promise in understanding how the immune system works, and why cells age and die or why they become malignant in response to environmental factors.

- Prevention or alleviation of birth defects by means of emerging techniques such as fetal surgery, drugs that inhibit premature birth, and screening tests for inborn errors of metabolism.

- Clinical studies toward prevention of diabetic retinopathy and senile cataracts.

NATIONAL LIBRARY OF MEDICINE

Question: We are concerned that the National Library of Medicine may be providing information from its computer base to foreign and domestic users, including profit-making organizations, at fees which recover less than the full cost of services provided. We have several questions regarding the fee structure charged by the National Library of Medicine. Does the current rate structure cover the costs of buying the literature in the first place (and other "creation" costs), as well as covering the costs of assessing the computer? If not, why not?

Answer: The current fees have been set to recover on an annual basis the total costs for providing tapes, approximately 95% of the cost of access, and approximately 60% of the total costs for creation and access costs. The tape and online fees charged have not been set to recover the total cost to the Federal Government of creating and providing access. The Library's basic policy on cost recovery is that the user community -- biomedical researchers, educators, health practitioners, and students -- should share the cost providing online access to NLM's databases. Specifically, the Library is required by law to acquire books and journals and to generate the data base needed to produce Index Medicus, which is one of the functions defined in its Act. This law says that the Secretary of DHHS, through the Library, shall:

"(1) acquire and preserve books, periodicals, prints, films, recordings, and other library materials pertinent to medicine;

(2) organize the materials specified in clause (1) by appropriate cataloging, indexing, and bibliographical listing;

(3) publish and make available the catalogs, indexes and bibliographies referred to in clause (2);

(4) make available through loans, photographic or other copying procedures or otherwise, such materials in the Library as he deems appropriate;

(5) provide reference and research assistance; and

(6) engage in such other activities in furtherance of the purpose of this part as he deems appropriate and the Library's resources permit."

(Sec. 382(a), 42 U.S.C. 276)

Over and above the costs associated with these indisputably required functions, the Board of Regents of the Library believes the biomedical user community should be assessed fair and reasonable charges for services. Also, the Library adheres to the view that all users should have equal access to NLM services and that all types or sectors of users should pay the same price for services. Equal treatment, shared costs, and fair prices are the bases for NLM policy.

This policy is consistent with congressional mandate as manifest in the Public Health Service Act. The pricing policies of NLM have been reviewed by congressional appropriations committees. Historically they have encouraged user charges but have supported the concept of equal access at an equal charge. The partnership through which NLM pays the cost to create the database and the users pay the cost to access the system has been supported. NLM user charge policies have been repeatedly endorsed by the Library's Board of Regents, and it has stood the test of user acceptance for approximately 20 years.

Question: What would you estimate your rates to be if "creation" costs were added to your fees?

Answer: The current fees recover about 60% of total costs, including "creation costs." To recover creation costs, it would be necessary to increase the current connect hour charge of $22.00 per hour during prime time and $15.00 per hour during non-prime time by 40% in the aggregate, or to an estimated level of $30.00 per connect hour.

Question: Should commercial-for-profit users pay the same rate charged non-profit organizations and private citizens?

Answer: NLM as a societal instrument charges all users on an equal basis. This is consistent with the policy formulated by its Board of Regents. The Department is examining this issue and intends to draw on two congressional studies already underway: one by the Office of Technology Assessment and one by the General Accounting Office.

NLM LEASING AGREEMENTS

Question: We have a few questions regarding NLM's agreements with commercial vendors who lease access to the on-line system and then retail your information to users at a profit. What fees do you levy against commercial vendors who buy and sell information from your computer base?

Answer: Currently NLM charges a minimum fee of $20,000 annually for leasing of its MEDLINE tapes. This amount is offset by use charges at rate of $4.00 per connect hour and $0.01 per citation printed offline.

Question: To what extent does NLM know how much vendors utilize your system? Can you depend on the honor system that is in use?

Answer: NLM enters into agreements with commercial vendors to lease tapes of its databases. Under new licensing agreements, a vendor is required to submit monthly reports to NLM outlining the connect hours and citations printed offline for that period. The license also stipulates usage reports are subject to an audit by the NLM. The reports received by NLM are similar to those provided by these vendors or other data base generators.

Question: If you are not getting accurate reports from vendors, what does this do to the accuracy of the bills you send them?

Answer: Given the terms of the leasing agreements with the vendors, as described above, there is no reason to doubt the accuracy of these reports. Our brief experience with the new system--which has been in place since January of this year--indicates that the reports seem to be accurate.

IMPACT OF CONTINUING RESOLUTION

Question: What has been the impact of the 1982 continuing resolution, which imposed the lower of the House or Senate figures and a 4% reduction beyond that?

Answer: That impact has, of course, reduced the overall budget for the NIH from $3.8 to $3.64 billion. The 4% reduction within that framework will still allow NIH to support almost 4,800 research grants. The NIH will have a 4% reduction in training dollars and will, therefore, support nearly 500 fewer trainees under the continuing resolution. We are continuing to provide approximately 50% of the institutional allowances paid in 1981.

In other research mechanisms, very little new activity will be possible in research centers and R&D contracts. We will not be able to mount all the clinical trials that we would like.

Intramural research will similarly suffer in that, although it would appear that it has only a 2% reduction, the October 1981 pay raise must be absorbed; therefore, the actual reduction is about 4%.

Although the reductions have impact on all budget mechanisms, we believe that, with the type of planning that has been suggested by the Institutes in the selection of clear priorities, we will be able to continue momentum within the framework of the 1982 continuing resolution level.

POSSIBLE CUTS IN OVERHEAD EXPENSES

Question: In light of current constraints on the budget, and the need to put adequate funds into research, what savings can you achieve in direct operations and program management in fiscal 1983?

Answer: The 1983 budget request contains only mandatory increases in direct operations and program management. In order to offset increased costs in travel, postage, supplies, printing, etc., we have reduced the use of overtime, restricted the printing and distribution of informational pamphlets, and reduced the number of conferences and workshops we support. We have also increased our use of contract airlines and other reduced fares for those trips that must be taken to carry out the NIH mission.

Question: What are your most important administrative concerns--and what are your least important concerns?

Answer: All administrative matters are of concern to the NIH, particularly during a time of economic restraint. A major concern centers on the inability to recruit rapidly and to retain the top quality scientists, physicians, and administrators required to carry out the NIH mandate. Efforts to control administrative costs in all areas have been increased, particularly in travel, equipment and supply purchases, and consultant services, without compromising the efficiency of administering programs or the integrity of the review system.

Question: What criteria do you use for determining your administrative priorities?

Answer: The highest priority goes to those areas where there is a legal requirement such as administering grants and contracts. Secondly, the NIH endeavors to comply with Congressional and Departmental objectives. In all areas, of course, the NIH attempts to perform its tasks in the most efficient and effective manner possible, so there are considerations of cost/benefit ratios.

NON-FEDERAL SUPPORT FOR RESEARCH

Question: How much are universities and research institutions receiving from private resources to support biomedical research? What is the private sector doing to assist research institutes?

Answer: The Department does not have access to detailed information on sources or amounts of funds made available to the universities and research institutions through the private sector. We estimate, however, that approximately $500 million was provided by non-Federal sources in research support to the universities and research institutions in 1981.

Nursing Programs

Question: A recent report on the supply and distribution of nurses by the Health Resources Administration predicts a sharp decline in the number of graduations from schools of nursing by the year 2000. It also notes that projected requirements, by the year 2000, exceed the supply estimates. What are your comments regarding the findings of this study?

Answer: The decline in graduation from schools of nursing is attributable to a number of factors including the decline in the overall number of high school graduates. However, it is anticipated that the supply of nurses will continue to grow although at a reduced rate. A congressionally mandated study on Nursing Education by the Institute of Medicine is currently underway to determine the need to continue federal support for nursing education, reasons for non-practice in medically underserved areas and recommendations for solutions to this problem, and nurse retention problems. Future legislative proposals will take into consideration the findings of this report and any other problems such as disparities between supply and requirements of nurses. Overcoming such problems will require the combined efforts of Federal, State, and Local governments, the health care industry, and the profession.

Question: What is the Administration's position with respect to the adequacy of the present supply of nurses?

Answer: The Second Report to Congress concluded that the aggregate supply of nurses would be roughly equal to the aggregate requirements in 1985. The Administration's principal concern is being directed toward problems of improved utilization and distribution of nurses and of increasing the numbers of nurses providing bedside care. While there is an acknowledged problem with shortage of nurses in certain work settings and locations, the availability of target funds will assist training institutions and hospitals to develop innovative solutions.

Question: What action is the Department taking to change certain basic conditions, such as low salaries, which contribute to the nursing shortage?

Answer: There are a number of factors beyond the purview of the Federal government which contribute to the nurse shortage in specific geographic areas and settings such as low salaries, lack of autonomy, "burnout", lack of opportunity for upward mobility, and work pressures resulting from insufficient staff. The Administration takes the position that these problems need to be addressed by the profession and by the hospitals while Federal dollars need to be directed toward problems of improved utilization and distribution of nurses and of increasing the numbers of nurses providing bedside care.

Question: The American Nurses Association says that the greatest need in nursing today is for nurses with advanced training. If this is the case, how can you justify an advanced training program which provides for a total of seven awards for fiscal 1983?

Answer: The Advanced Nurse Training project will provide institutional support through grants and contracts to collegiate schools of nursing programs for the preparation of professional nurses at the Master's or doctoral level. The seven projects will be awarded to those continuation projects that have been the most successful and emphasize the highest priority clinical nurse specialties; maternal-child health, geriatrics, community health, acute care, adult care and medical/surgical care.

Question: Also, how can you justify the elimination of the Professional Traineeship Program, which is designed to support students in graduate school?

Answer: The Administration believes students should contribute a greater share to the cost of education. FY 1983 funds will be used for programs addressing high priority issues such as improving specialty and geographic distribution of health practitioners and health promotion and disease prevention activities.

Question: If two major areas of concern are geographic maldistribution of nurses and providing retraining and continuing education opportunities for those RN's who have left the profession and want to come back, why are reductions being sought in the special projects program which is set up to address these needs?

Answer: The overall 1983 budget request is consistent with new legislation and constrained fiscal resources to target Federal resources to promote National priority objectives in health professions training and development. Improving geographic distribution of nurses and providing retraining opportunities for those RN's desiring to re-enter the workforce are two of the five special purposes in Nurse Special Project authority. In the 1983 budget request for Nurse Special Projects, 20 percent of funds appropriated will be allocated for improving the geographic distribution of nurses in underserved areas and a portion of the funds appropriated will be directed toward projects which retrain nurses re-entering the nursing profession.

DISADVANTAGED ASSISTANCE

Question: To what extent are students from disadvantaged backgrounds increasingly deterred from undertaking and completing education for one of the health professions because of the increasing costs of this education?

Answer: The increasing costs of a health professions education are a deterring factor to some students in undertaking and completing education in these fields. The current average resident tuition for public medical schools is $2,300 per year, and $9,300 for private schools while in 1975 the corresponding average tuition costs were $1,200 and $4,400 respectively. Using medicine as the example, there were 42,624 applicants for the first year class in 1974-75; five years later there were 6,000 fewer applicants. However, while the cost of medical school affects the number of annual applications, workforce supply and demand factors also contribute to an individual's decision on whether to apply to medical school.

HEALTH PLANNING

Question: Can you fund Health Systems Agencies to any extent through the Block Grants? How? Please be specific?

Answer: A Block Grant mechanism could be used to fund HSAs after the FY '82 grant cycle has been completed. However, changes in the authorizing legislation would be required to incorporate the HSAs in the Block Grant Program. The changes in the authorizing legislation would probably determine the maximum amount to be retained by the State for managing the "pass through" of funds and the basis for providing funds to support local health planning.

Question: What is the Administration rationale for proposing the termination of the health planning program?

Answer: The Federal Health Planning program has been ineffective in almost every effort it has tried, particularly in cost containment, and has been divorced from State and local political processes. Further, the health planning program is a regulatory burden on the health care industry that must be eliminated to foster free market concepts, as opposed to existing barriers to entry.

Question: How effective is the Certificate-of-Need process in controlling unnecessary and costly capital investment by hospitals and other health facilities?

Answer: The report of the HRA program review of CON and the recently completed CBO paper "Health Planning: Issues for Reauthorization" examined this issue and stated that there is no available evidence that on a national basis CON alone has had a demonstrable effect on aggregate hospital costs or investments. Both of these reports, however, continue with a note of caution regarding interpreting the evidence to date as being conclusive.

Question: Do you view the health planning program as one which acts to thwart competition or as one which is worth keeping, although perhaps with scaled-down expectations?

Answer: The Administration continues to believe that the answer to spiraling health care costs is the implementation of a competition strategy and changes in reimbursement practices. For those areas where health planning is desired at the local level, we believe that it is more appropriately controlled by State and local governments.

AGING PROGRAMS

Question: Thirteen of the fifteen members of the Senate Committee on Aging, including the Chairman and ranking member, have expressed concern that the proposed elimination of the Labor Department's jobs for the elderly program would "have a damaging impact on the ability of senior centers and nutrition sites to serve Older Americans". What portion of the existing staff of local senior centers and nutrition sites are currently funded by the Labor Department's Community Service Employment Program for Older Americans?

Answer: The states reported in FY 1980 that there were 7,000 enrollees who, on the average, were working 21 hours per week in nutrition projects. These enrollees complement the 38,592 paid staff and the 289,398 volunteers, 238,111 of which are elderly. In addition, there were 5,000 enrollees working approximately 20 hours per week in recreation and senior centers.

Question: To what extent will cutbacks in the Fiscal Year 1983 budget requests for Administration on Aging programs further curtail staff of local senior centers and nutrition sites?

Answer: It is impossible for us to identify specific numbers of staff affected by reductions or increases in funding. A number of options exist as to how programs can be administered with increased or reduced funding levels. For example, some programs may opt to defer renovations or alterations of facilities used as senior centers in order to maintain staffing levels. These decisions will be made at the local level.

Question: What efforts are being made to find other sources of funding to offset the potential loss of Federal money to administer local aging projects.

Answer: In order to maintain service levels to the extent possible, AoA is pursuing two objectives aimed at strengthening the financial management and effective and efficient use of Title III programs. The first objective is to increase the level of program income. The following activities are designed to increase contributions from participants:

- determining the past and current level of program income expenditures by area agencies, and analyzing state and area agency policies and procedures governing the use and accountability for such funds;
- follow-up with state and area agencies to urge them to improve income accountability and expenditures for Title III services;
- identification and dissemination regarding models of best practice for use by area agencies in generating program income; and
- carrying out a national public information campaign which will indicate the benefits to be achieved from successfully managing this sizeable resource (public information materials to be developed and issued during FY 1982/83).

As part of an 18-month effort, there will be identification of areas such as models of best practice and information to be disseminated.

Based on the attainment of this objective, participant contributions for FY 1982 are estimated to reach $92 million, and for FY 1983 to increase to $120 million.

The second objective will be to take steps to improve the program and financial management of state and area agencies, including actions in response to GAO and Inspector General recommendations. As part of its regular assessment of State Agencies, AoA will focus on those financial and management concerns which are impeding the program from operating at maximum efficiency. AoA will also provide special technical assistance aimed at improving State Agency financial management, including the development of model performance-based payment techniques for use by Area Agencies in managing Title III funds awarded to local service providers.

Question: If efforts are unsuccessful to replace the loss of federally funded staff, to what extent do you feel services to the elderly would be adversely affected?

Answer: As mentioned earlier, it is impossible to determine the impact of changes in funding levels on staff. Therefore we cannot estimate the impact of the changes in staff or services.

As we discussed above, the Administration on Aging is pursuing two objectives aimed at maintaining service levels to the extent possible.

HEAD START REGULATIONS

Question: What is the status of plans to re-write Head Start regulations?

Answer: The Office of Human Development Services is reviewing the Head Start regulations and may submit a proposal to the Office of the Secretary on the possibility of revising the current regulations.

Question: Exactly what changes in Head Start regulations are being considered and why?

Answer: OHDS is considering the following possible initiatives in connection with the regulations: consolidate, streamline and simplify existing requirements; outline essential program and administrative requirements; preserve the unique characcteristics and comprehensive nature of Head Start; and provide the legislatively mandated protections to Head Start grantees and delegate agencies.

In light of the President's strong support of Head Start, we feel it is appropriate to undertake efforts, such as reviewing regulations, in an effort to improve the efficiency and quality of the program.

Question: How do you respond to those who fear revised regulations will weaken the high performance standards that have made Head Start such a successful program?

Answer: We have not proposed eliminating or weakening the Head Start performance standards. The Congress has established a statutory requirement that the comprehensiveness of these standards be maintained. HHS will not make any proposals to weaken important performance standards.

Question: In short, if the clock works, why fix it?

Answer: We agree that Head Start works. One of the reasons Head Start works is that the program has been open to self-examination and change over the course of its life. We believe the federal management of Head Start can be improved and that changes in regulations might advance that objective.

CUTS IN SOCIAL SERVICES

Question: Can you tell us whether the press report is accurate, that the 1981 level of 7.7 million people receiving Social Services will decline to 4.4 million recipients in fiscal 1983?

Answer: The National Association of Social Worker's study appears to have used a straight-line methodology of reduced dollars plus the inflation impact to project a reduction in the number of people that will receive services. This methodology at best would provide a very gross estimate. The study also uses estimated primary recipients, 7.7 million, for the projection of people to receive services. The total number of persons receiving services in FY 1981 was in excess of 10 million people. Thus the use of primary recipient data is misleading. For example, assume a working mother with two children receiving child day care, the mother is the primary recipient but not the two children. Also, straight-line methodology assumes the same mixture of eligibility requirements, recipients, and services which is not necessarily correct. Even with the time limitations of the first year, States have made the following type changes to their programs in FY 1982:

- prioritizing services and dropping less effective and less vital services
- targeting eligibility on those most in need of services
- using other Federal funds for services, Aid to Families with Dependent Children for day care and Medicaid for family planning
- increasing user fees based on ability to pay part of the cost
- transferring other Block Grant funds to the Social Services Block Grant

Question: Is it going to be standard practice that your budget justification material to Congress for Block Grant programs will not contain estimates of service levels so that Congress will have difficulty judging the impact of requested funding?

Answer: There is no legislative authority for requiring statistical reporting under the Block Grant. The only requirements for Block Grants are the pre-expenditure report, the post-expenditure report and the audit report. The post-expenditure report and the audit report will be submitted by the State not less often then every two years. The Department is working with the American Public Welfare Association and State representatives to establish a voluntary system for reporting that would provide workload data. Until we can get such a system established there will be very little workload data available.

IMPACT OF CHILD WELFARE BLOCK GRANT ON DISCRETIONARY SERVICES

Question: Assuming that Congress is again unwilling to place a cap on these entitlement payments in fiscal 1983, isn't there a danger that most of the $380 million budget request would be absorbed for mandatory Foster Care payments, with very little left over for child welfare and training services?

Answer: If the block grant is not enacted and no cap is placed on foster care, most of the $380 million might be absorbed by foster care. This increase in cost is one of the reasons that we are proposing the block grant.

Question: Wouldn't this defeat the purpose of the law, which is intended to de-emphasize reliance on foster care, and get children into permanent, adoptive homes?

Answer: Were a block grant not enacted and if no cap were place on foster care, the rising cost of foster care payments might force States to use most of the their funds for foster care, thereby defeating the intent of the law. That is why a block grant is proposed. By eliminating categorical funding provisions, States would be provided incentives to place greater priority on prevention and permanent placement than on foster care payments. While many of the protection provisions in the current law would be maintained, States would be afforded greater flexibility in determining how to best meet their individual needs.

Question: What is your current estimate of Foster Care and Adoption Assistance entitlement payments in each of fiscal years 1982 and 1983?

Answer: The Fourth Continuing Resolution, P.L. 97-161, which makes funds available through September 30, 1982, provides a maximum of $300 million for foster care in FY 1982. The Department assumes these are the only funds that will be available in FY 1982. Of this amount, it is estimated that approximately $30 million would be transferred to child welfare services. In addition, $5 million is available for adoption assistance. Under current law, the estimated combined entitlement for foster care and adoption assistance would be $352 million in 1982. Of this amount, an estimated $35 million would be transferred to Child Welfare services.

In 1983, the Administration proposes to consolidate child welfare, foster care, adoption assistance, and child welfare training programs under a Child Welfare Block Grant. The proposal would allocate $380 million to the States to be used at their discretion in providing support for these programs. Proposed legislation will be sent to the Congress in the near future. Under current law, the combined estimated entitlement for foster care and adoption assistance in 1983 would be $397, million of which approcimately $45 million would be transferred to child welfare services.

Question:

The Department of Justice is currently rewriting the 1978 HEW Section 504 guidelines under the direction of the Bush Task Force on Regulatory Relief. Section 504 provides education and employment opportunities to qualified handicapped persons, among other things.

What role, if any, does the Department of Health and Human Services have in rewriting the 1978 HEW Section 504 guidelines?

Answer:

The Department of Justice is reviewing the existing government-wide regulation under Section 504 of the Rehabilitation Act. The government-wide regulation sets the basic compliance standards and procedures that all departments and agencies must follow in enforcing Section 504 with respect to their federally assisted programs. Although the Justice Department circulated a preliminary draft of changes to departments and agencies on an informal basis in January, a notice of proposed rule-making has not yet been issued. The Department of Health and Human Services will continue to have an opportunity to comment on all proposed changes that are made.

Question:

Exactly what changes are being proposed to change existing regulations designed to insure access of the handicapped to public buildings and transportation facilities, as required by Section 504 of the Rehabilitation Act?

Answer:

The existing Section 504 government-wide regulation provides that federally assisted programs and activities must be accessible to qualified handicapped persons. This general standard applies to federally assisted transportation systems. In addition, structural changes to existing facilities may have to be undertaken in those cases where such changes are necessary to make a program accessible to handicapped persons. Since the Department of Justice has not yet issued a revised regulation for public comment, it is not yet clear whether or to what extent existing standards may be modified. At the same time, the Department of Transportation may have adopted some changes in applying Section 504 standards to public transportation systems.

Question:

Why is the coordination of these guidelines for the Federal government being transferred from your Department to the Justice Department?

Answer:

The existing government-wide regulation under Section 504 was issued by the former Department of Health, Education, and Welfare on January 13, 1978. At that time, this Department was responsible for coordinating enforcement of Section 504 government-wide pursuant to Executive Order 11914. However, the coordination responsibility was transferred to the Justice Department under Executive Order 12250, signed by former President Carter on November 2, 1980. It was felt that this transfer would improve coordination and consistency since the Department of Justice already had the responsibility to coordinate the enforcement of other civil rights laws.

Question:

What is the rationale for proposed changes in the existing "Section 504" regulations?

Answer:

Because the original Executive Order 11914 was rescinded by Executive Order 12250, which covers coordination of all civil rights statutes, certain changes are in order as a practical matter. In addition, it is our understanding that the Section 504 government-wide regulation is being reviewed in order to resolve problems that have arisen in enforcing Section 504, to update and clarify standards, to bring about greater uniformity in enforcing all the civil rights laws, and to ensure that the standards are cost-effective.

Question:

What is the timetable for promulgating proposed changes in "Section 504" regulations?

Answer:

The Justice Department is not under any statutory or legal timetable in regard to reviewing or revising the Section 504 government-wide regulation. Preliminary, draft changes were circulated informally to departments and agencies for review on January 29, 1982. The Justice Department plans to issue a notice of proposed rule-making for public comment this year.

REFUGEE FLOWS

Question: What role do you play, Mr. Secretary, in helping to determine how many refugees should be allowed in every year?

Answer: I have a very direct role, together with the Secretary of State and the Attorney General. Our views are presented to the President for his consideration in developing a proposed level of admissions for the coming fiscal year. It is this proposed level which is then presented to the Congress for consideration during the consultation process which is prescribed by the Refugee Act of 1980. Following the receipt of Congressional recommendations, we again have the opportunity for providing the President with our recommendations, which he considers in reaching a final determination.

Question: How many refugees are presently coming in each month?

Answer: During the first six months of FY 1982, refugee arrivals averaged approximately 8,100 per month. This included approximately 6,600 Southeast Asian arrivals and 1,500 arrivals of other refugee groups per month.

Question: How many are expected in fiscal 1983?

Answer: The Department's budget request for the Office of Refugee Resettlement for FY 1983 is based upon the arrival of 114,500 refugees during that year?

72,000	Southeast Asian refugees
11,000	Soviet Jewish refugees, and
31,500	Refugees from all other parts of the world.

The actual numbers of refugees to arrive during FY 1983 will be determined by the President in September 1982 after consultation with the Congress.

REFUGEE EDUCATION

Question: The Department is requesting no new fiscal 1983 funds for refugee education assistance. Since the Department acknowledges a responsibility to reimburse States for cash and medical costs related to refugees, why does it not acknowledge a similar responsibility to help pay for educational costs?

Answer: We believe that in fact the Department has met its responsibility for helping finance the special education costs of refugee and entrant children. From FY 1980 to FY 1982, we will have awarded nearly $90 million to State and local education agencies for special education services to these children -- almost $70 million for refugees and $20 million for entrants.

We believe that additional funding is not needed in the 1983 budget in order to carry out Federal responsibilities to help education refugee and entrant children.

These funds have been utilized to augment other elementary and secondary education programs providing special disadvantaged and bilingual assistance. The Federal government has provided resources to enable school systems to estabish special programs for refugee children. We do not believe though that continued assistance for maintaining these projects is an essential responsibility of this Department. Special education projects for refugees and entrants should be supported through ongoing Federal education programs and by local funding since refugees are productive tax paying members of their local communities.

REFUGEE DEPENDENCY RATE

Question: Costs in the refugee and entrant programs have increased, in large part due to increased refugee dependency on Federally-reimbursed cash and medical assistance. What steps are you taking to try to reduce the refugee dependency rate?

Answer: Several steps have been taken to reduce the dependency rate:

(1) ORR has issued a new policy to reduce the period of eligibility for refugee cash and medical assistance from thirty-six to eighteen months. It is anticipated that this policy change will increase incentives to seek employment.

(2) ORR is finalizing State plan guidelines which will require the States to prepare social services funding plans that show that social service funds are targeted to reduce welfare dependency. Specifically, the States will need to give priority to the provision of employment services and English language training. State plans which do not meet these criteria will be returned for modification.

(3) ORR will increase its efforts to assure that the States are effectively applying sanctions prescribed for refugees who refuse appropriate offers of employment.

(4) ORR is increasing its technical assistance to States to reduce the dependency rates. ORR is currently compiling descriptions of best practices of employment projects, which will direct States towards projects with potential for increasing refugee employment. ORR is also putting together technical assistance packages regarding English as

a Second Language (ESL) for all Regional Offices to use in helping the States to strengthen the provision of ESL services to refugees.

Question: Does the Department plan any new approach, such as a State-wide demonstration, to test alternatives to the current welfare-oriented system of assisting refugees?

Answer: We are not currently considering a statewide demonstration to test an alternative to the present system of providing cash and medical assistance to refugees. We have, however, proposed that up to five percent of the refugee social service funds be used to test new approaches to resettlement and self-support, and we would expect to use some of those funds to try new approaches to increasing employment and reducing dependency.

Question: What are these?

Answer: We have only recently published a proposed allocation formula for refugee social services funds that would allow up to five percent of the funds to be used on such projects. Therefore, we have not finalized plans for such projects.

Question: Is a block grant program, granting considerable flexibility to States in handling refugees, a possible approach?

Answer: We are not looking toward a block grant approach at this time. The President's Interagency Task Force on Immigration and Refugee Policy reviewed this question and concluded that the existing categories of refugee aid -- cash and medical assistance, training and services -- should be continued in order to assure effective and efficient use of refugee benefit funding. However, we have introduced greater flexibility with the proposed targeted assistance program for Cuban and Haitian entrants in FY 1982 and for both refugees and entrants in FY 1983. This program provides funding to States which they may apply towards project grants to assist refugee and entrant populations, where supplementation of currently available resources is necessary due to the high concentration of refugees and entrants.

REFUGEE REGULATIONS

Question: The Department has issued, in interim-final form, regulations governing the refugee and entrant programs which limit Federal reimbursement for AFDC-level and Medicaid benefits to eighteen months, rather than the previous period of thirty-six months. However, if a refugee or entrant goes on the rolls of a state general assistance program, the Federal government will reimburse States for the cost of the general assistance program for an additional eighteen months. What is the main rationale behind these new regulations?

Answer: The new regulations revise the assistance eligibility only for those refugees and entrants who are ineligible for Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), and Medicaid. The Refugee Resettlement Program (RRP) provides Federal reimbursement to States for 100 percent of the costs of cash and medical assistance provided, during the first 36 months after entry into the United States, to such refugees in accordance with applicable program rules and requirements and the administrative costs of providing such assistance. The new regulation permits 100 percent Federal reimbursement for refugee cash and medical assistance for an eligible refugee for the first 18 months that a refugee is in the United States. For a refugee who has been in the U.S. more than 18 months but less than 36 months, the new regulation permits a State, at its option, to seek RRP reimbursement for the cost of General Assistance (GA) provided to such a refugee.

The new regulation supports several major objectives:

(1) To reduce the likelihood of unnecessary welfare dependency resulting from extended periods of special support;

(2) To reduce the degree of special treatment afforded to refugees, which results in unequal treatment among low-income populations; and

(3) To reduce total refugee welfare costs while continuing to relieve States of refugee cash and medical assistance costs during a refugee's first 36 months in this country.

CUBAN/HAITIAN ENTRANT REPROGRAMMING REQUEST

Question: Mr. Secretary, the Department has sent to the Committee a request to reprogram $48 million in Cuban/Haitian Entrant Domestic Assistance funding, $35 million of which would be used for targeted assistance to States with high concentrations of entrants, and $13 million for costs of Reception and Processing.

It is clear that the Department needs reprogramming authority for the $13 million for Reception and Processing, since the amount available for Reception and Processing (at present, $19.2 million) was set in the Committee Report, and you propose to increase that amount to meet additional costs.

It is our thinking that the Department also needs reprogramming authority for the targeted assistance funds, since this is a considerable sum of money for an activity which the Committee has never previously funded. It's been argued, however, that language in our Committee Report gives you all the authority you need for the targeted assistance program.

Is it your opinion that reporgramming authority is required to allow funding for the targeted assistance program?

Answer: HHS believes the Committee Report language provides the appropriate and necessary authority for the targeted assistance program, without the need for a reprogramming request. However, there is a need for additional funds for the Reception and Processing activity. In order to transfer funds from the Domestic Assistance activity into the Reception and Processing activity, HHS has made a formal reprogramming request to this Committee and is awaiting its approval. Since this formal request was made, and given the uncertainty of whether reprogramming for targeted assistance is required, HHS has included a request to the Congress for official approval of the transfer of funds for the targeted assistance program. In this manner, the Congress will be fully aware of HHS' intent and be able to take official action as it may see fit.

Question: Is it not so that without this reprogramming, there will be a $13 million shortfall in funding for Reception and Processing, and that this will necessitate a supplemental to cover these costs?

Answer: Without the $13 million transfer from Domestic Assistance into Reception and Processing, there would be a shortage of funding in the latter activity area. Without an approval of the reprogramming, a supplemental request would be the only alternative available to cover the added costs in Reception and Processing.

BLOCK GRANTS

Question: The Subcommittee is aware that the Administration may propose to amend several provisions of the Low Income Energy Assistance, Maternal and Child Health and Primary Care Block Grant statutes that it considers burdensome on State governments. Chief among these are provisions that restrict administrative costs, establish program earmarks and require State matching requirements, among others.

If you relax restrictions on administrative costs, won't you assure that these costs will just leave less money available for providers of essential services?

Answer: We believe that the transfer of these responsibilities and resources, with diminished reporting requirements and the like, will reduce administrative costs, overall. Furthermore, we are confident that State administration will be at least as efficient as that of the Federal Government. It is our opinion that States will do their utmost to allocate resources to actual care and services and that they will contain administrative overhead at the lowest possible levels.

Question: It seems premature to provide State governments with additional flexibility when we have so little quantitative and qualitative information on State implementation of the block grants. How can you justify repeal of these provisions at this time?

Answer: We have a significant level of actual experience in this area because a substantial part of the Title V Maternal and Child Health appropriation has long been allocated to States on a "formula" basis which is very similar to a block grant authorization. In addition, there is a very long history of health program administration at the State level and we feel our experience with State health authorities is adequate to justify our confidence in block grant administration by the States.

Question: In your opinion, what level of Federal oversight is appropriate?

Answer: The Administration has sent to the Congress proposed legislation to amend the Maternal and Child Health Block Grant provision. This proposal sets forth the appropriate level of accountability for the new relationship with States contemplated by block grants. As in other block grants, the Maternal and Child Health Block Grant calls for public notice of the report of intended expenditures, an annual report on activities, requirements for independent audit and authority to withhold funds for violations.

The amendments to the Primary Care Block Grant, which will be forwarded to Congress shortly, will bring this block grant into line with other block grants including provisions relating to accountability.

STATUS OF THE SOCIAL SECURITY TRUST FUNDS

Question: Mr. Secretary, probably the issue that most concerns Americans is the present status and future security of the Social Security Trust Funds. Recently, the Trustees of the Social Security system issued a report indicating that the system is indeed in quite poor straits. By what date will the Old-Age and Survivors Trust Fund run out of money? By what date will the Disability Trust Fund run out of money?

Answer: The recent Trustees' report states that under present law, which provides for temporary interfund borrowing, the Old-Age and Survivors Trust Fund would not be able to pay benefits on time by July 1983. The Disability Insurance Trust Fund is projected to grow rapidly in both the short range and the long range. However, even if extended interfund borrowing between the OASI and DI trust funds were permitted, both funds combined would become unable to pay all benefits on time sometime in the latter half of 1983 under all four sets of economic and demographic assumptions in the 1982 report.

Question: Would a delay or a reduction in the cost-of-living adjustment this July have a positive effect on the Trust Fund situation? How much?

Answer: Any proposal which would delay or reduce the automatic benefit increase for this June, which is reflected beginning with the July 2, 1982 checks, would reduce outgo and increase interest income for the Old-Age and Survivors and the Disability Insurance Trust Funds. The extent of the impact on the Trust Funds would depend on the proposal.

Question: What suggestion do you have to provide for the long term security of the trust fund?

Answer: Last fall the President asked the leadership of Congress to join him in appointing a bipartisan National Commission on Social Security Reform. The goal of this Commission, which was established on December 16, 1981, is to make recommendations for putting Social Security back on a sound financial footing and to forge a working bipartisan consensus so that the necessary reforms will be passed into law. The Commission is expected to present its report by the end of the year. The Administration is committed to work with Congress in considering these recommendations and enacting appropriate legislation.

SOCIAL SECURITY SYSTEMS PLAN

Question: The Department of HHS recently announced its new five-year plan to upgrade the computer system at the Social Security Administration. This plan has an estimated cost of $478 million. How serious is the situation out at the Social Security Administration right now?

Answer: The current situation in SSA's computer facilities is extremely serious. The computer operations have suffered a continuous degradation for almost a decade, and the crisis is now apparent in all aspects of SSA's ADP environment--software and operating systems, the computer equipment, the communications system, and the personnel who work on it.

SSA is highly dependent on computers to effectively administer its programs and is now only marginally capable of performing critical program functions such as issuing monthly checks to 36 million Social Security beneficiaries and 4 million SSI beneficiaries. Because of its serious ADP problems, the Agency sustains its operations with very costly manual processes and defers action on many critical projects that would benefit the public and result in substantial program and administrative savings. Further, millions of dollars are wasted in the administration of SSA's programs due to an antiquated computer system employing various levels of technology spanning more than two decades. As an example of this situation, implementation of the normal cost-of-living benefit increases last year required 20,000 hours of computer processing, day and night, over a period of four months. A system using today's technology should be capable of performing this task in a matter of a few days.

Question: Will additional funds, above what is already requested for the Limitation on Administrative Expenses in SSA, be requested in the fiscal 1983 budget for computer improvement?

Answer: At this time we think that SSA will need additional funding in FY 1983 for the Limitation on Administrative Expenses for the systems modernization plan. However, our estimates are still being reviewed to determine if we will request a budget amendment for FY 1983 to cover the additional expenses.

AFDC

Question: The Committee notes that the Social Security Administration is planning to "borrow forward" roughly $929 million for a shortfall in the estimate for the AFDC program costs. This represents nearly a 15 percent underestimate of program costs.

How are estimates for AFDC made?

Answer: AFDC cost estimates are derived from two principal variables--AFDC families and average benefits--taking into account the effects of savings from legislative proposals and administrative improvements. These estimates reflect basic assumptions with respect to the state of the economy, demographic trends affecting family formation and composition, proposed or enacted Federal legislation, and anticipated State program and policy actions. Variations in each of these factors can exert a significant impact on the number of AFDC families receiving benefits or on the average benefit which such families are likely to receive.

Question: What assurance can the Committee have that a similarly inaccurate estimate for fiscal 1983 has not been submitted?

Answer: Our estimates are based on the best data available on the many factors which affect the AFDC program, such as economic conditions, unemployment, implementation dates of program changes, and State error rates. About half of the shortfall for FY 1982 is a result of changes in economic conditions since the original estimates were made. Most of the balance of the shortfall occurred because the provisions of the Omnibus Budget Reconciliation Act of 1981 were not implemented by the States as quickly as anticipated in the budget because of legal and regulatory delays.

The AFDC program estimates for FY 1983 were prepared consistent with the economic and policy assumptions underlying the President's budget. These assumptions anticipate that the economy will be recovering from the current recession, that continued progress will be achieved by the States in reducing payment errors and increasing administrative efficiency, and that both the Congress and the State and local governments will actively support and fully implement the provisions of P.L. 97-35--the Omnibus Budget Reconciliation Act of 1981--and the legislation proposed in the FY 1983 budget. The AFDC budget estimates for FY 1983 are in accord with those expectations.

Question: What steps is SSA taking to improve the accuracy of its Assistance Payments budget estimates?

Answer: Budget estimating invariably entails a degree of uncertainty. To minimize estimating errors, SSA will continue to pursue and promote research efforts to develop the improved forecasting methods and analytical techniques needed to evaluate and anticipate program trends.

WORKFARE

Question: Last year Congress rejected an Administration proposal to require so-called "workfare" programs for all AFDC recipients. Congress voted instead to permit States to set up workfare programs. This year, the Administration is again requesting compulsory workfare programs, and states that enactment of this requirement will save $49 million. Based on what data and assumptions does the Administration assume such large savings from this proposal?

Answer: Savings for this provision are based on the assumption that mandatory Community Work Experience Programs (CWEP) will reduce the number of people receiving AFDC. We believe that when a strengthened work requirement is attached to the AFDC payment many able-bodied recipients will no longer find welfare to be an attractive alternative to private employment. In the Food Stamp demonstration projects, 28% of the cases dropped off assistance after these additional work requirements were implemented. In contrast, our estimates assume that only about 14% of the employable caseload will drop from the roles.

Although we have not included savings from increased employability of AFDC recipients through work experience, we expect that this factor would increase savings significantly.

The savings estimates are net savings of the mandatory program over already projected savings for the optional program. This interaction is responsible for the apparent savings reduction in FY 1985. The savings attributable to the mandatory provisions themselves does not decrease. However, the net figure (mandatory over optional) decreases because the savings projected for optional CWEP increased sharply in that year.

Question: Given Congressional opposition to mandatory workfare last year, why does the Administration believe the same Congress will enact such a program this year?

Answer: We are certain that Congress recognizes the need to keep able-bodied welfare recipients involved in work activities, to make work requirements for welfare recipients meaningful, and to demonstrate that welfare is not an alternative to work for employable individuals.

CWEP is an essential component of our comprehensive work strategy, providing an opportunity for recipients to gain experience, make a contribution and maintain an attachment to work.

CWEP provides work experience which will complement jobs created through work supplementation programs, job search activity, and the increased training opportunities for AFDC recipients which will be provided in the Administration's companion job training bill.

Question: What kind of work would AFDC recipients be given as part of compulsory workfare programs?

Answer: Participating AFDC recipients will be performing a variety of activities which serve a useful public purpose. Examples of the kind of work can be found in existing workfare programs. In Utah's Work Experience and Training (WEAT) program, participants provide services within agencies at all three levels of government. In Oklahoma's new Community Work Experience Program (CWEP), participants are being assigned to a broad range of jobs including day care aides, hospital and institutional aides, public works and maintenance workers and clerical workers. In West Virginia's new CWEP program, assignees are working as custodians and building maintenance aides, police helpers and ambulance assistants, library and park aides, meter maids, receptionists, clerical workers, and laborers. West Virginia has developed more than 3,300 slots with 350 sponsors. Many of these slots are Comprehensive Employment and Training Act (CETA) vacancies.

Question: Under the optional program, how many States have chosen to set up workfare programs?

Answer: Since most States have been focusing their attention on implementing the provisions mandated by the Omnibus Budget Reconciliation Act of 1981, they have had limited opportunity so far to set up workfare programs. Nevertheless, we expect at least 20 States to implement CWEP programs in the near future.

Three States (North Dakota, Oklahoma and West Virginia) implemented CWEP programs in January. Five States are implementing

CWEP demonstration programs. We know of eight other States which intend to implement CWEP programs this year. Several other States have bills under consideration in their State legislatures to authorize CWEP or related work experience programs. Utah has been running a program similar to CWEP for more than 7 years. Finally, at least one State, Massachusetts, is implementing a work experience program as part of its WIN demonstration program.

Question: What evidence is there from actual workfare programs that they achieve their goal of getting welfare recipients to work and reducing welfare costs? Can you give us some hard figures on this?

Answer: We have evidence from other workfare programs that mandatory work activities can reduce welfare caseloads and increase employment.

In Utah's WEAT program, 35 percent of those selected for participation through 1980 had their cases closed prior to being assigned. Nearly half of these cases were closed because the individual reported full-time employment. Of those who were actually assigned to projects, 34 percent obtained employment.

Results from the first seven pilot workfare projects run for food stamp recipients also show reductions in dependency. Preliminary data suggest that the majority of project participants left the project before actually participating in workfare, receiving an exemption, or being sanctioned for non-compliance. Those who were assigned to the workfare program were less apt to remain on assistance after 3 months than other recipients. About 28 percent became subject to sanctions for refusing to participate. Women who were subject to workfare were more apt to obtain employment than other female recipients. During the 3 months following work registration, they earned an average of $186 more than women in the comparison group.

COMBINED WELFARE ADMINISTRATION BLOCK GRANT

Question: The Administration is proposing a new Combined Welfare Administration Block Grant, to provide States with funds to pay for the administration of the Medicaid, AFDC, and Food Stamp programs. This program would be capped in fiscal 1983 at 95 percent of the fiscal 1982 level, which will produce savings of $259 million.

At a time when the Administration is proposing to insist on a zero percent error rate in these programs by fiscal 1986, how do you rationalize capping administrative payments for AFDC and Medicaid?

Answer: There is no proven correlation between the level of administrative expenditures and error rates. Between fiscal years 1979 and 1980, eleven States decreased both administrative costs per case and erroneous expenditures per case. During the same period twelve States increased both the administrative costs per case and the erroneous expenditures per case.

The problem of erroneous expenditures, therefore, is not solved by simply increasing administrative expenditures. More likely, solutions will vary from State to State because of variations in the characteristics of State programs, and demographic and economic differences. All of these solutions fall within the purview of State management of public assistance. By reducing the Federal burden on State management through the proposed block grant we expect to promote more efficient State management and reduce barriers to more creative solutions to these and other State management problems.

Question: What savings do you believe will accrue as a result of consolidating payments for State administration of welfare programs?

Answer: The consolidation of these three programs will save the Federal Government $302 million in fiscal year 1983 through elimination of duplicate staff effort for each of the programs, excess personnel and other factors. The estimated savings to the Federal Government over a 5-year period for these three programs is as follows:

($ in Millions)

	FY 83	FY 84	FY 85	FY 86	FY 87
AFDC................	$-41	$-89	$-136	$-181	$-223
Medicaid............	-218	-284	-393	-454	-528
Food Stamps.........	-43	-61	-84	-104	-124
Total..........	$-302	$-434	$-613	$-739	$-875

Question: Since eligibility for Medicaid, AFDC and Food Stamps varies, how can a consolidated administrative grant improve their management?

Answer: Even though eligibility for these three programs varies, many of their administrative costs are the same. Under current law, these administrative costs are allocated and reported separately for each program according to a complex set of Federal requirements.

Eliminating the current practice of matching State and local costs on an open-ended basis will return control of administrative costs to the States, reduce accounting system and administrative effort required to allocate costs and provide a strong incentive for States to increase administrative efficiency and improve program operations.

CHILD SUPPORT ENFORCEMENT INCENTIVE PAYMENTS

Question: There has been some concern that incentive payments to States under the Child Support Enforcement program may be too generous. (NOTE: At present, the Federal Government pays 75 percent of all administrative costs of the CSE program, plus an incentive payment to the States equal to 15 percent of the Federal share of collected funds.) What plans does the Administration have to review the current incentive payments system?

Answer: We have been reviewing the entire funding structure of the Child Support Enforcement program in an effort to strengthen it. We hope to be sending to you very shortly our legislative proposal, the effect of which has been included in this budget submission. Our proposal changes the funding structure to link funding more directly to program performance, and is intended to encourage States to both increase collections and operate more cost-effective programs.

Question: Under the present incentive payments system, many States make a net profit on the CSE program. What use do States make of the "profit" from this program? Is there any limitation on the use of funds?

Answer: There are no restrictions on the use of the incentives or the States' share of the collections. States may use these funds for whatever purpose they choose, including purposes other than child support enforcement.

Question: For the record, provide a list of all the States' administrative payments for CSE, and the net recovery they make, broken out by collections and incentive payments.

Answer: We would be happy to provide the table.

CHILD SUPPORT ENFORCEMENT DATA ON STATE SHARES 1/

1981

	State Share Expenditures	State Share Collections	Incentives Payments	Net Recovery*
Alabama	1,409,224	1,427,682	627,964	646,422
Alaska	626,459	372,697	113,004	-140,758
Arizona	693,433	743,399	147,298	197,264
Arkansas	852,609	697,349	384,898	229,638
California	24,014,918	50,267,285	9,296,128	35,548,495
Colorado	1,422,321	1,944,514	754,576	1,276,769
Connecticut	1,937,056	7,820,583	2,325,320	8,208,847
Delaware	628,122	1,000,749	300,059	672,686
Dist. of Col.	813,687	564,018	169,328	-80,341
Florida	2,684,780	4,965,124	2,080,183	4,360,527
Georgia	1,198,375	2,444,795	1,077,952	2,324,372
Guam	40,373	34,141	1,816	-4,416
Hawaii	495,370	1,563,546	497,160	1,565,336
Idaho	365,904	890,080	428,333	952,509
Illinois	3,358,036	6,026,941	1,936,064	4,604,969
Indiana	1,503,419	3,804,430	1,502,402	3,803,413
Iowa	1,453,397	6,586,129	2,105,711	7,238,443
Kansas	962,449	2,386,875	769,527	2,193,953
Kentucky	1,502,970	1,376,962	665,943	539,935
Louisiana	2,389,651	2,151,582	1,180,540	942,471
Maine	448,076	1,422,640	699,036	1,673,600
Maryland	3,196,722	7,513,335	2,131,270	6,447,883
Massachusetts	3,292,438	18,452,586	5,596,552	20,756,700
Michigan	7,582,602	43,652,022	11,550,309	47,619,729
Minnesota	3,203,606	8,918,464	2,736,984	8,451,842
Mississippi	494,017	139,612	57,361	-297,044
Missouri	1,842,287	2,467,367	887,964	1,513,044
Montana	280,355	366,637	152,652	238,934
Nebraska	593,480	1,225,997	416,668	1,051,185
Nevada	663,454	420,963	125,166	-117,325
New Hampshire	255,794	837,620	343,211	925,037
New Jersey	6,864,455	15,602,430	4,680,845	13,418,820
New Mexico	549,496	590,492	282,171	323,167
New York	15,888,810	23,877,718	7,163,338	15,152,246
North Carolina	2,172,234	3,959,045	1,724,424	3,511,235
North Dakota	255,897	566,572	219,237	529,912
Ohio	4,591,216	13,698,029	4,574,168	13,680,981
Oklahoma	1,229,065	810,074	326,403	-92,588
Oregon	2,876,053	5,458,964	1,845,427	4,428,338
Pennsylvania	7,511,975	16,619,160	5,399,439	14,506,624
Puerto Rico	310,438	126,662	73,146	-110,630
Rhode Island	397,476	1,511,330	504,626	1,618,480
South Carolina	452,249	898,952	380,964	827,667
South Dakota	256,595	372,412	117,925	233,742
Tennessee	1,175,403	1,124,897	568,285	517,779
Texas	3,653,132	2,686,968	1,113,979	147,815
Utah	1,245,461	2,547,753	1,238,314	2,540,606
Vermont	225,514	610,616	288,891	673,993
Virgin Islands	76,460	38,654	22,517	-15,289
Virginia	1,776,911	3,840,035	1,129,578	3,192,702
Washington	2,942,559	9,534,508	2,816,935	9,408,884
West Virginia	602,949	710,515	388,818	496,384
Wisconsin	2,846,128	13,832,299	4,944,612	15,930,783
Wyoming	69,411	255,424	68,886	254,899
Nationwide Totals	128,175,271	301,759,633	90,936,307	264,520,669

* State share of collections, plus incentive payments, minus State share of expenditures

1/ The data reflect the latest actuals received from the States as of March 15, 1982.

CHILD SUPPORT ENFORCEMENT LEGISLATIVE CHANGES

Question: As you know, the Administration has assumed legislative savings resulting from enactment of controversial proposals in its FY 1983 budget. But in the case of the Child Support Enforcement program, the Administration is assuming $145 million in savings based on proposals which have not even been submitted to Congress yet. What is your comment on this action? Are you prepared now to inform Congress what these proposed initiatives are?

Answer: We will be sending the Social Welfare Amendments of 1982 to the Congress shortly. The Child Support legislation included in the Amendments proposes to restructure the financing of the Child Support Enforcement program to improve cost-effectiveness and efficiency of State operations. The budget also proposes that States retain a share of child support collections for families not receiving AFDC benefits to cover administrative costs for these non-AFDC cases.

AFDC

Question: The Administration is proposing a series of legislative changes in the AFDC program, which are designed to save $1.15 billion in fiscal 1983. A major study by the University of Chicago concluded that changes made in last year's Reconciliation bill removed the incentive to get off welfare by taking a job. Do you agree with this criticism?

Answer: No. The University of Chicago's Center for the Study of Social Policy recently analyzed the purported impact of last year's AFDC legislation and the potential effects of the Administration's 1983 budget proposals on low income families. The study claims work incentives for low income families will be eliminated, that low income families will become more, not less, dependent on welfare and that projected savings will not materialize. The study is defective in three major ways:

1) it contains some inaccuracies;

2) the figures cited do not support the conclusions; and

3) it makes unexamined philosophical assumptions which cannot be supported.

Although the study deals with both last year's changes and the proposed 1983 changes, with respect to AFDC it deals with the latter only briefly, and, where it does so, erroneously. For example, it claims that energy assistance will be counted dollar-for-dollar against AFDC benefits, whereas the Administration's AFDC proposal is to count energy assistance only to the extent that it duplicates the amounts for heating and cooling that are in the AFDC payment standard. The study also claims that the Administration proposes to remove children from the grant when they reach the age of 16, whereas the Administration proposes to remove only the needs of the caretaker when the youngest child reaches 16. With respect to AFDC, the findings by-and-large go over the same ground as the study the University of Chicago did last year with the main focus again being on the elimination of the $30-and-one-third after four months and the standardization of the work expense disregard.

The main difficulty with the study is that, despite the fact that it presents masses of numbers, the study presents no direct, empirical evidence for the claim that the AFDC provisions have decreased, or will decrease, the work effort of AFDC recipients. Furthermore, analysis of the data that the study uses to arrive at this conclusion shows that, because it uses data from out of their original context, the very relevance of the data to the conclusions is doubtful.

One clear example of this is the claim that some families will actually be worse off financially if they work than if they don't. With respect to AFDC, the main factor giving rise to this "finding" is the study's use of average work expenses from the 1979 AFDC Recipient Characteristics Study. Since that study was conducted prior to the 1981 changes when there were unlimited work expenses that could be deducted from a recipient's countable income, there was no incentive for recipients to economize in their work expenses. In fact there was a positive incentive for recipients to maximize their expenses to stay on the rolls at higher income levels. In most cases, the only mandatory work expenses for low income families are FICA and State and local income taxes, since their Federal income taxes are low to non-existent. Other expenses such as transportation and clothing are within the control of the individual, and considerable economies can be realized by recipients. Last year's AFDC changes provide the incentive for recipients to do this, and thus, the study's use of earlier data on work expenses does not give a true picture.

A second weakness of the study is that it implicitly assumes throughout, and sometimes even directly asserts, that the previous system of disregards was effective in moving families into independence. Thus the study asserts that last year's provisions "eliminate the incentives to work for families that are trying to earn their way off the rolls" (p.1). This completely ignores the abundant evidence that the previously permanent $30-and-one-third disregard, which is the main factor in the changes engendered in the study's "benefit reduction rates" by the AFDC changes, had just the opposite effect -- it served to maintain AFDC families on the rolls indefinitely, without increasing the percentage of AFDC families that worked. Thus both before and after the introduction of the $30-and-one-third, and indeed throughout the 60's and 70's, about 14% of AFDC mothers had earnings. Furthermore, in 1967, before the $30-and-one-third was enacted, about one-third of the households who left the rolls did so because of increased earnings, but by 1979 less than 10% did so. Clearly the reason for this was that the disregard allowed recipients, even with relatively high incomes, to continue to receive AFDC and thus preserved their dependence on the system. This allowed AFDC to become an income supplement program for individuals able to work, rather than a social safety net for those with no other source of income. Thus rather than providing an effective incentive for welfare recipients to "earn their way off the rolls" by making work more attractive than welfare, the permanent $30-and-one-third only served to make the combination of work and welfare more attractive to some individuals than just work alone.

The problem of making work more attractive than welfare suggests a third difficulty with the University of Chicago analysis; except for one page, buried well into the report (p. 23), it ignores the possibility of using work requirements to make welfare less attractive. The only form of work incentive that the study takes seriously is a positive answer to the financial question whether at a particular moment an individual contemplating work will have more, and how much more, money by working than by not working. In so doing, it ignores the insoluble problems of posing the work/welfare issue simply in financial terms. If one rejects work requirements, the only arrangement that will provide a low benefit reduction rate for welfare families is either a system that pays extremely low benefits to those who are unable or unwilling to work and thus penalizes those in the first category, or a system that allows individuals with such high incomes to continue to receive welfare that a substantial segment of the population would permanently depend on other taxpayers. The only way out of this dilemma is to take work requirements seriously. No system of welfare will work, nor will it be accepted by the American people, which allows an able-bodied individual to calculate and choose: "Will I be better off if I work or if I allow myself and my family to become dependent upon the work of other individuals?" By enforcing current work requirements and by strengthening them, potential able-bodied recipients would not be given the choice of "decid[ing] to become totally dependent on welfare" (p.21).

The study briefly suggests that work requirements of this sort are not workable. It suggests that it will be difficult to document if a person quits or loses his job. Actually this decision is routinely made with respect to Unemployment Compensation. Furthermore, able-bodied applicants and recipients can be required to look for work and to participate in community work experience. The study suggests that the latter has been tried and has failed, because the work that would be provided does not usually develop skills that would help the recipient to find other employment. Three points need to be made here. First, any job provides skills, such as good work habits and a work history, which are relevant to finding other jobs. Second, States are already identifying jobs such as school or hospital aides, which clearly provide valuable experience in finding other jobs. Third, with respect to the work incentive issue, the point is not simply that the community work experience jobs should lead directly to private sector jobs, but that the choice of an individual not to work, and instead be supported by the labor of others, should not be an available option. Thus, the study ignores the posibility of reforming welfare by systematic strengthening of work requirements and instead suggests the return to a system which has proven itself to be hopelessly defective.

Question: How would the new changes proposed this year try to create a bias in favor of getting a job?

Answer: There are several proposals which are intended to strengthen work requirements under the AFDC program. They are designed to ensure that States can involve all able-bodied individuals in work activities which can lead to early employment in the private sector. There are basically two components to the work strategy: job search by applicants and involvement in work or training by all recipients who are able to participate. Requiring employable AFDC applicants to participate in job search activities from the date of application will divert some of these applicants into jobs and reduce the number of individuals coming onto the rolls. For those whose job search is unsuccessful, the States will have the flexibility to develop creative programs to assist those individuals in improving their employability and chances for private-sector employment. The programs available to the States will include the Community Work Experience Program, Work Supplementation Program, WIN Demonstrations, and job training which will be authorized under the Administration's bill for job-training administered by the Department of Labor.

Through these proposals, the employability of applicants and recipients will be enhanced and dependency on welfare reduced. Also, welfare will be eliminated as an alternative to work for employable individuals.

SUBCOMMITTEE RECESS

Senator SCHMITT. The subcommittee will recess until Thursday, April 15, when we meet in this room at 1 p.m. to discuss the fiscal 1983 appropriation request of the Department of Education with Secretary Ted Bell.

[Whereupon, at 4:40 p.m., Wednesday, April 14, the subcommittee was recessed, to reconvene at 1 p.m., Thursday, April 15.]

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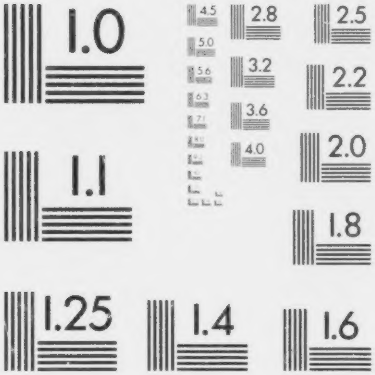
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